ASTHO Bilingual Health Initiative

Report and Recommendations:

State Health Agency Strategies to Develop Linguistically Relevant Public Health Systems

Association of State and Territorial Health Officials

July 1992

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Special acknowledgement goes to Public Health Service Project Officers Barbara Favola, Office of Minority Health and Joe Baldi, Bureau of Health Care Delivery and Assistance for guidance throughout the project. Thanks are also due to the five state health departments profiled in this report, and the states which participated in the needs assessment questionnaire and sent additional information on state bilingual health initiatives. Several community based health organizations also contributed valuable background information for this report. The ASTHO Executive Committee endorses the recommendations of the Bilingual Health Initiative.

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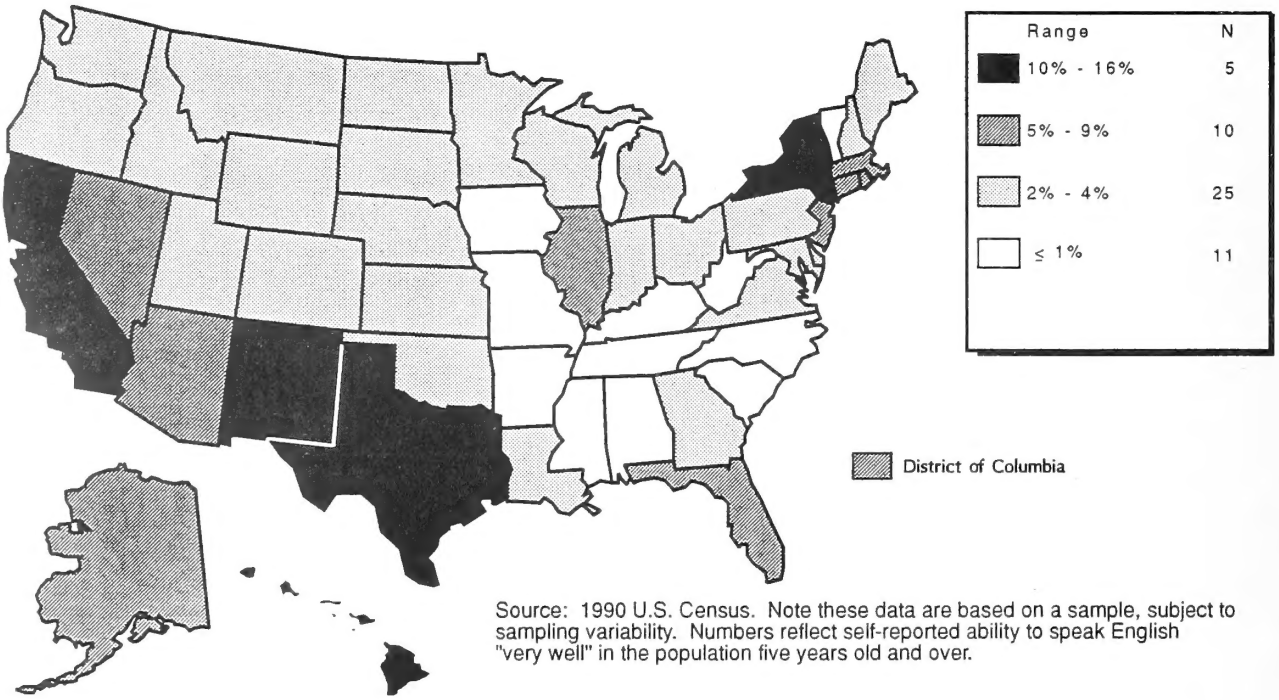
Table of Contents

LIMITED ENGLISH PROFICIENT POPULATION IN THE U.S., BY STATE



Source: 1990 U.S. Census. Note these data are based on a sample, subject to sampling variability. Numbers reflect self-reported ability to speak English "very well" in the population five years old and over.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS June 1992

ASTHO Bilingual Health Initiative

Executive Summary

The ASTHO Bilingual Health Initiative Project was funded by the federal Office of Minority Health to examine the role of state public health agencies in addressing the public health needs of non-English speaking and limited English proficient populations. The Bilingual Health Initiative Report is based on findings of an ASTHO needs assessment examining state health agency programs and policies targeting linguistic minorities, detailed case studies of five state health agency programs, and information obtained from community based organizations targeting linguistic minority populations. The needs assessment focused on key areas of assessment, policy development, and assurance for state public health agency programs and policies. While most state health agencies indicated having some type of data on their linguistic minority populations, relatively few have conducted public health needs assessments of those groups. State health agency policies on linguistic and culturally relevant services, such as translations and interpreters, cultural competency training, and community outreach, also vary in the degree to which they are formalized. Based on the ASTHO needs assessment results and information on "best practices" in state health agency programs and community projects, the ASTHO Minority Health Advisory Committee developed the following recommendations for state public health agencies and the federal government addressing the public health needs of non-English speaking and limited English proficient populations:

STATE POLICIES

Recommendation: In order to address state Year 2000 objectives for health access and health status, state health agencies should set goals and describe how the goals will meet the linguistic and cultural needs of non-English speaking and limited English proficient populations.

Recommendation: State health agencies should establish written policies in order to institutionalize the agency's approach to addressing language-appropriate health care. Policies should address linguistic and cultural needs assessments in agency programs, coordination of resources for limited English speaking clients, standardizing the quality of services such as interpreters and translations, community outreach, and cross-cultural training of agency staff.

COORDINATION OF SERVICES

Recommendation: State health agencies should establish a mechanism to assure coordination of public health services for linguistic minorities, and to assure that personnel in all programs and divisions in the department are aware of this coordinating role.

Recommendation: State health agencies should coordinate with related state agencies such as Education, Welfare, and Social Services to comprehensively address health needs of linguistic minority populations.

DATA DEVELOPMENT

Recommendation: State health agencies should improve infrastructure for the collection of data on racial, ethnic, and linguistic groups by developing capacity to dis-aggregate data, and should use data on minority ethnic and linguistic traits in program planning efforts.

COMMUNITY OUTREACH

Recommendation: States should identify a process for continuous or frequent input from linguistic minority communities on state health agency policies and programs affecting those communities in

order to assure development of culturally and linguistically appropriate programs and policies. Community participation should also be solicited in the needs assessment and evaluation processes.

FUNDING

Recommendation: State health agencies should allot resources to assure that linguistic minorities have access to culturally and linguistically appropriate public health services and prevention programs, including high quality translation and interpreter services and culturally competent health care workers.

TRANSLATIONS AND INTERPRETING

Recommendation: State health agencies should define and enforce quality standards for written translations and interpreting competency.

SERVICE DELIVERY

Recommendation: State health agencies should maintain accurate needs assessments and provide language appropriate services when necessary. Through grant and contract requirements, reporting requirements, and audits, state health agencies should assure that organizations receiving funding from the agency also adequately address linguistic access for targeted populations.

Recommendation: State agencies should work with state and federal policy makers, state, local, and community agencies, communities and other leaders, including the private sector, to replicate effective programs.

Recommendation: Where possible, staff of programs serving cultural and linguistic groups should be representative of the population being served. State health agencies should develop programs and policies which promote recruitment and training of culturally and linguistically competent health care professionals and community health outreach workers from targeted linguistic populations.

CULTURAL AND LINGUISTIC COMPETENCY TRAINING

Recommendation: State health agencies should define goals and objectives, along with developing and implementing policies, for training agency staff and health providers on multilingual and multicultural aspects of ethnic populations. Training should be aimed at achieving acceptable levels of competence and at a minimum, should address the following issues: cultural values and traditions, family structure, communication styles, attitudes affecting health behavior, approaches to healing, and traditional folk remedies of the targeted populations. Training should also address mental health issues and stress management.

Recommendation: State health agencies should utilize the skills of non-traditional health care workers where possible. States should consider training members of linguistic minority groups as health outreach workers to facilitate communication with targeted communities. States may also investigate options to utilize the skills of immigrant health professionals who are members of linguistic minority groups, either through licensing procedures or special arrangements with the agency, to provide services to targeted linguistic minorities.

EVALUATION OF PROGRAM EFFECTIVENESS

Recommendation: State health agencies should evaluate public health programs based on established objectives, such as Year 2000 goals, and should emphasize the need for continuous monitoring of both state health program effectiveness and changes in health status indicators of the targeted populations.

Recommendation: State health agencies should systematically survey clients from targeted linguistic groups to assure the effectiveness of state programs and policies designed to promote access to

preventive and public health programs. Assessments should address linguistic and cultural relevance of services, use of services, and client satisfaction.

COLLABORATION WITH THE FEDERAL GOVERNMENT

Recommendation: The federal government should take a more pro-active role in disseminating information to states on multilingual and multicultural health programs and multimedia materials nationwide, as well as disseminating information on federal grants and policies targeting linguistic minorities, by better utilization of existing clearinghouse mechanisms.

Recommendation: The federal government should insert language in requests for proposals (RFPs) and cooperative agreements that allows states to tailor federally funded projects to specific targeted linguistic minority populations. Funding policies should allow for flexibility in the responses of state health agencies with very small numbers of people in any specific linguistic audience.

Recommendation: Federal policies and programs should take a leadership role in collecting linguistic minority health needs assessment tools and making them available to all state health agencies. Federal financial support should be available to state health agencies for short term multilingual and multicultural programs until needs assessments are conducted and long range planning can be done.

Recommendation: Federal funds should assist states in developing a mechanism for the coordination of ethnic and racial minority health initiatives, such as Offices of Minority Health where desired, and should include staff training.

The full report provides background information in Part I. Part II details the rationale for each recommendation, using examples from state and community based programs. Part III profiles "model" programs and policies in Colorado, Massachusetts, Michigan, Utah, Wisconsin targeting linguistic minorities which may be of interest to other states for possible adaptation to specific demographic needs. The appendices contain a results of the ASTHO needs assessment, selected statistics on linguistic populations based on 1990 U.S. Census information, examples of "model" policy initiatives, and a list of multicultural resource organizations.

Part I

Introduction

♦ *Developing a Context for Linguistic Minority Health Issues* ♦

In 1984, the Secretary's Task Force on Black and Minority Health initiated the first comprehensive analysis by the Department of Health and Human Services of the disparity in deaths and illnesses experienced by racial and ethnic minority populations in the United States. Since that time, a concerted effort at the federal, state, local, and community levels has been undertaken to address the needs of minority populations in order to increase access to health services and to decrease health disparities. In 1990 the Department of Health and Human Services issued its report, Healthy People 2000: National Health Promotion and Disease Prevention Objectives, listing over 100 objectives targeting the needs of growing racial and ethnic minority populations. The Healthy People report has become a partial blueprint for planning and policy development at the state and national level, as states have developed their own priority objectives and strategized ways to improve the health of state residents.

Lack of standardized data obscures health disparities and the effect of cultural and linguistic barriers to health care for ethnic groups such as Hispanics, Asians and Pacific Islanders, Native Americans, Alaskan Natives, and Caribbean Islanders. Although race-specific data has been compiled on health indicators for whites and blacks, little standardized data is available on individual ethnic populations. Lack of data is often attributed to the small size of ethnic and racial populations, and to the difficulty in designing appropriate health status and health needs assessment instruments. Where information is available, the disproportionately poor health status of refugees, new immigrants, migrant farm workers, and isolated groups of non-English speaking people has been documented through intermittent public and private health assessments.

Many clear differences in the health status of ethnic groups have been identified. For example, the diverse population of Hispanics in the United States, mainly consisting of people of Mexican, Puerto Rican, Cuban, and Central and South American descent, represents 8.1 percent of the country's population. In AIDS cases reported in 1989, however, Hispanics represented 16 percent of people with AIDS. Hispanics also have a higher risk for non-insulin dependent diabetes. In Texas, the rate of Hispanic morbidity from diabetes compared to that of the non-Hispanic white population was more than 2 to 1. One in 8 Mexican Americans will develop diabetes, compared to one in 15 for non-Hispanic whites. Disparities in health status also exist between Hispanic subgroups. Hispanics overall have a 5.6 percent risk of low birth weight babies, and non-Hispanic whites have a 5.2 percent risk level; the rate for Puerto Ricans is much higher than average (7.9 percent), but the rate for Cubans is lower (5.0 percent).

In the Asian and Pacific Islander population, representing 3 percent of the total U.S. population and 15 percent of the minority population, health indicators also fall below those of the general population, in addition to varying significantly among ethnic subgroups. Problems associated with low birth weight among Asian and Pacific Islanders reached a rate of 6.5 percent in 1980, 7.4 percent for Filipinos, compared to the non-Hispanic white rate of 5.6 percent (OMH-RC, 1989). Rates of smoking, no exercise, and lack of screening for cholesterol and cervical cancer among Vietnamese are higher than the average in California (MMWR, 1992).

Other ethnic and linguistic groups in the U.S., both indigenous groups and new refugee populations, also have poor health indicators. According to studies on Native American Indian and Alaskan Native

populations, rates of diabetes (12.2 percent) and gallbladder disease (7.4 percent) are significantly higher than for the U.S. population as a whole (5.2 percent and 5.4 percent respectively). Although the gap in life expectancy between Native Americans and the white population has shrunk dramatically over the last 50 years, Native Americans still die from infectious disease at twice the national rate. Preliminary screening of new Haitian refugees arriving in Florida showed that 100 percent of the refugees require some type of immunization, while 52.1 percent displayed positive results to TB testing. This sudden influx of Creole-speaking refugees has presented Florida health officials with both programmatic and financial challenges.

♦ *The Impact of Language Barriers on Public Health* ♦

According to the 1990 U.S. Census, six percent of the U.S. population report that they do not speak English "very well". California has the highest percentage (16 percent), followed by Hawaii (12 percent), and New Mexico, New York, and Texas with 10 percent in each state. Thirteen states have six percent or more of their population that speaks minimal English, while eleven states have a limited English speaking population of one percent or less. (Please refer to Appendix A for state specific information on selected limited English speaking populations.)

Language is one decisive indicator of the critical relationship between cultural accessibility and access to health services. Ability to speak the language of health providers has been shown to be a stronger predictor of use of health screening services than ethnic identification in the U.S. The 1982-1984 Hispanic Health and Nutrition Examination Survey (HHANES) showed ability to speak English increases the capacity of Hispanic individuals to effectively use health services, and that ability to speak English correlates significantly with utilization of preventive services (Solis et al, 1990).

In combination with language, other ethno-cultural barriers which impede access to health services include cultural, structural and financial barriers. For example, refugees dependent on public support may not be able to access "English only" public agencies; new immigrants with religious restrictions or "folk" prescriptions may resist routine physicals and preventive health efforts; non-English speaking migrant workers, even if transportation is available to get them to clinics, cannot explain their health problems at clinics that do not have interpreters. Communication in appropriate languages and sensitivity to the accompanying cultural and socio-economic factors are fundamental aspects of health access, and are key elements to be addressed in policy and program development at the federal, state and local levels.

♦ *The Role of State Public Health Agencies* ♦

State public health agencies are responsible for health policy planning and program development statewide. According to the Institute of Medicine Report The Future of Public Health, state public health agencies are the "pivotal actors in our federal system" working to achieve national health goals, and have primary responsibility at the state level to carry out assessment of needs, policy development, and assurance of public health measures. The functions outlined by the IOM correspond to the major components of public health problem solving: identification of the problem, mobilization of necessary effort and resources, and assurance that vital conditions are in place and that crucial services are received. Fulfillment of these state health agency roles is critical in order for states to meet health objectives. Public health programs have increased recognition of the essential need to eliminate the gap in health status between ethnic and racial groups and the overall population, and to improve access to health care for all sectors of the population. Attention to the health needs of racial and ethnic populations is particularly urgent in view of the changing demography of this Nation; ethnic minority populations are increasing faster than the U.S. population as a whole, 34 percent for Hispanics and 47.6 percent for Asians and Pacific Islanders, compared to 6.6 percent in the general population. Based on projected

population growth rates, states such as California and Texas refer to ethnic and racial populations as the "emerging majority."

Although all state public health agencies have responsibilities in needs assessment, policy development, and assuring that the public's health needs will be met, the agencies fulfill these roles through diverse mechanisms. There is wide variety in the types of programs situated in state health agencies, as well as in the funding and staffing policies promoted by each agency. Most state health agencies do deliver some types of health services in such areas as maternal and child health, tuberculosis control, sexually transmitted diseases, HIV/AIDS, and immunizations. Most also make grants and contracts with local public health agencies and community organizations for the delivery of community based services. Where state agencies are not directly delivering services, the agency plays a key role in the development of statewide health policies to promote health and assure progress in meeting state health objectives. State agencies are also responsible for tracking and monitoring health status and the effectiveness of programs, and for filling gaps where needed. In recent years many state public health agencies have experienced severe budget cuts due to state fiscal problems, a factor which has often limited their capacity to implement new or expanded public health programs.

In the ASTHO needs assessment conducted for this report, twenty-six percent of respondents commented that the very small size and uneven distribution of the limited English speaking populations in the state were major impediments to addressing health needs of these groups. Although the numbers of linguistic minorities are small in many states, those communities tend to be clustered in urban areas. These areas are seeing an increasing need to address issues in providing linguistically and culturally appropriate health services. Tennessee, for example, has a limited English speaking population of less than 1 percent. The state has a growing population of Kurdish refugees in Middle Tennessee, however, and has had much difficulty in locating health interpreters for this ethnic group. State health agencies are recognizing that their responsiveness to health needs of linguistic minorities cannot be determined only by the size of the population, but must also address trends such as geographic concentration, migration, and population growth.

♦ *About this Report* ♦

Federal guidelines established in the Disadvantaged Minority Health Improvement Act of 1990 (P.L. 101-527), charge the Department of Health and Human Services to assist in the provision of linguistically appropriate primary health care and preventive health services to populations who do not speak or understand English well. One objective of Healthy People 2000, for example, is to increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic populations. State public health departments, through the state Year 2000 Objectives, play a key role in linking federal mandates and community based strategies to comprehensively improve the health status of the U.S. population and eliminate disparities in the health status of ethnic and racial populations. Information in this report describes the contributions of state health agencies to this multilingual, multicultural health initiative, and makes recommendations for strengthening public health interventions targeting linguistic minority populations.

The ASTHO Bilingual Health Initiative is a project funded through the federal Office of Minority Health to assess current state health agency policies which affect the provision of multilingual and multicultural health services and to recommend policy initiatives which assure culturally appropriate access. The specific ethnic and racial groups targeted for this study include only non-English speaking and limited English proficient (LEP)[1] populations. This project was guided by the ASTHO Minority Health Committee, consisting of state health officers, minority health officials, and representatives of national multicultural health organizations.

The ASTHO Bilingual Health Initiative has three major components. First, ASTHO conducted a national needs assessment on all state and territorial public health agencies. Thirty six agencies responded with information on policies and programs relating to linguistic access. Second, ASTHO examined five state health programs in depth and collected information on community based strategies for reaching and serving ethnic and racial populations. The state profiles in Part III describe programs and policies in Colorado, Massachusetts, Michigan, Utah, and Wisconsin, each of which has "model" elements potentially of interest to other states. Finally, using results from the needs assessment as well as examples from state programs and community projects, the Minority Health Committee developed recommendations for state health agencies and the federal government. The recommendations have been endorsed by ASTHO's leadership.

The ASTHO Minority Health Committee recognizes that "appropriate" access to public health services goes beyond language; access involves combined cultural and linguistic sensitivity and competence.[2] These factors must contribute to institutional policies in order to improve access and service delivery to linguistic minorities, and ultimately, to improve health in minority populations. To address these factors, the Committee suggested that state agencies focus on a number of components, including:

- assessment of the scope of public health problems for linguistic minorities;
- coordination of resources for limited English proficient populations both within public health agencies and interdepartmentally;
- defining quality standards for linguistically relevant health service delivery;
- training needs of staff, including cross-cultural competency training;
- utilization and training of multilingual and multicultural staff in agency programs and in the agency leadership;
- developing infrastructure for establishing race, ethnic, and language specific databases relating to health;
- working with communities to involve targeted populations in the needs assessment, program planning, and delivery of public health programs for racial and ethnic populations;
- developing measures for monitoring effectiveness of interventions; and
- using outcome measures and health status indicators to replicate successful interventions.

These elements are discussed throughout Part II "Recommendations on Improving Responsiveness to Health Needs of Linguistic Minorities." Additional details can be found in state by state profiles as well as the appendices, which contain sample documents defining policies and policy objectives from selected state public health agencies.

Notes

1. LEP - limited English proficient; general term used in this report to represent all populations which are non-English or limited English speaking.
2. The term "cultural competence" used throughout this report means a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables them with the capacity to respond to the unique needs of populations whose cultures are different than that which might be called 'dominant' or 'mainstream' American" (Issacs, Benjamin 1989).

Part II

Recommendations for Improving Public Health Responsiveness to Linguistic Minority Health Needs

RECOMMENDATIONS TO STATE HEALTH AGENCIES

The following recommendations are based on the findings of a needs and resources assessment conducted by ASTHO to examine state public health agency activities which promote multicultural and multilingual access to public health services. (Please refer to Appendix B for a summary of the needs assessment results) Effective strategies utilized by local and community organizations to increase access to health services were also examined. The recommendations were developed by the ASTHO Minority Health Committee and endorsed by the ASTHO Executive Committee.

♦ *The Need for State Policies to Improve Access for Linguistic Minorities* ♦

The ASTHO needs assessment showed that states have a variety of policies addressing the language appropriateness of public health services. A majority of states have policies that require the agency to provide educational and informational material in languages other than English, and a number have policies on the use of interpreters. Many fewer states have policies addressing training and hiring of bilingual health care workers, or on the hiring of bilingual staff for the agency (only 23 percent of states). Most states (69 percent) said that they encourage appropriate linguistic service delivery and training of health care workers even if they do not have specific policies.

In several model state programs, state health agencies have developed written protocols for assuring that linguistic minority populations have access to health services. For example, California conducts a language survey on a periodic basis. Based on results of the survey, which tallies the number of staff encounters with non-English speaking clients, departments and divisions set new targets for employing personnel competent in the predominant languages used. Another model, Wisconsin, specifies by administrative order that the agency will meet the needs of linguistic minorities. Programs and services in the Wisconsin Division of Health are required to comply with the language directive either by hiring bilingual staff or using translators and interpreters.

Recommendation: In order to address state Year 2000 objectives for health access and health status, state health agencies should set goals and describe how the goals will meet the linguistic and cultural needs of non-English speaking and limited English proficient populations.

Recommendation: State health agencies should establish written policies in order to institutionalize the agency's approach to addressing language-appropriate health care. Policies should address linguistic and cultural needs assessments in agency programs, coordination of resources for limited English speaking clients, standardizing the quality of services such as interpreters and translations, community outreach, and cross-cultural training of agency staff.

♦ *Coordination of Linguistic Services* ♦

Another factor in state agency responsiveness to linguistic needs is the presence of a formal administrative point for coordinating minority and linguistic issues. Approximately 34 percent of respondents reported that they have administrative units to make referrals and coordinate services for

linguistic minority groups (Figure 1, page 13). In the Massachusetts Department of Public Health, the Office of Refugee and Immigrant Health serves a coordination and quality assurance role. The Office makes referrals to bilingual, bicultural health care providers and assures that translations are prepared in a high quality, culturally appropriate manner. State Offices of Minority Health are also frequently charged with coordinating policies and programs targeting all minority groups, including linguistic minorities, to assure that these populations have appropriate access to public health interventions.

Several of the model state agency programs also have developed resources for other divisions and agencies who encounter limited English speaking clients. For example, Michigan has developed a Bilingual Migrant Resources Directory based on recommendations of an inter-departmental migrant health committee. The directory, which catalogues resources available to migrant and seasonal workers, was distributed statewide to migrant health centers and other agencies serving this population. Michigan has also developed an internal network to assure coordination of minority issues, including language, within the Department of Public Health. The network consists of representatives from each of the departmental programs who meet regularly and develop objectives for programs sponsored in the Department.

Coordination of programs within agencies and between related agencies is particularly important when several public health programs, for example, both Refugee Health and Maternal and Child Health clinics, see clients who are linguistic minorities. State Offices of Minority Health are frequently charged with performing these coordination functions, although other programs such as refugee or migrant programs often have this responsibility. The Colorado Refugee Health Care Access Program in the Colorado Department of Health has a particular emphasis on coordinating services. Co-located in the Department of Social Services, the Department of Health's bilingual community health workers are trained to educate clients on health and related programs available for refugees, such as Medicaid and other benefit programs.

Recommendation: State health agencies should establish a mechanism to assure coordination of public health services for linguistic minorities, and to assure that personnel in all programs and divisions in the department are aware of this coordinating role.

Recommendation: State health agencies should coordinate with related state agencies such as Education, Welfare, and Social Services to comprehensively address health needs of linguistic minority populations.

♦ ***Data Development*** ♦

State health agency strategic planning is often driven by health status indicators obtained at the national, state and community level. Needs assessment is a key component of program planning and development, and is one of the major public health responsibilities outlined in the Institute of Medicine Report. The majority of state health agencies (80 percent) report that they do have current data on the number and location of limited English proficient (LEP) populations (Figure 1). The difficulty they experience is in determining the health status of these populations and in determining the impact of language on access to public health services. Often where census data is used to identify population groups, numbers are not accurate due to small census sample size and failure to distinguish racial and ethnic groups. Only one fourth of the state health agencies reported that they have public health needs assessment data on their LEP populations (Figure 1). Almost half of the respondents reported that the lack of health needs assessments is a major impediment to program and policy development to address the health needs of linguistic minorities (Figure 2).

Several states have demonstrated innovation in developing databases on the public health needs of linguistic minority populations by working directly with targeted communities to develop health related

data. The Michigan Office of Minority Health, for example, funds community based groups representing the racial or ethnic group of interest. Michigan's Hmong Health Needs Assessment clearly documented the needs of that population; it was conducted through a contract to a community based group which interviewed extensively in the Hmong community. Collaboration with community organizations has lead to more expansive health needs assessments, crossing state borders to assess the population of interest. For example, the Southeast Asian Refugee Regional Community Health Project (SEARCH) is a two state, four city program in Ohio and Michigan. SEARCH has a commitment to data collection and community needs assessment in addition to community outreach and direct service delivery. National multicultural organizations such as the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO), the Association of Asian/Pacific Community Health Organizations (AAPCHO), and the Asian American Health Forum, also frequently collect health related data on specific ethnic groups.

Recommendation: State health agencies should improve infrastructure for the collection of data on racial, ethnic and linguistic groups by developing capacity to dis-aggregate data, and should use data on minority ethnic and linguistic traits in program planning efforts.

♦ *Community Outreach* ♦

Most state health agencies obtain some type of input from linguistic minority communities when developing policies and programs. Most frequently, state agencies meet with community representatives (63 percent of agencies), meet with local governments or hold public hearings (34 percent), or conduct surveys (20 percent). One model state has created a formal advisory committee to provide continuous input on racial and ethnic health initiatives. Utah's Ethnic Health Committee is a formal coalition consisting of representatives from Asian, Black, Hispanic, Native American, and Polynesian communities. The Committee assisted in planning a statewide Ethnic Minority Health Conference in 1991, which served to identify needs and priorities of each ethnic group in the state. Ethnic workgroups were convened at the conference to review data on health status, and then developed priority lists of health needs. The Ethnic Health Project also surveys communities about health, including questions on physical, psychological, social, and attitudinal aspects of health needs. The Massachusetts Department of Health also maintains a strong community base by conducting jointly sponsored programs with community based organizations and by using community leaders to review informational material and translations.

Community based health organizations often have the advantage of being located in or near the communities being served, as opposed to state agencies, which have a statewide focus. Still, some aspects of community-initiated outreach are applicable to state planning. Many community programs conduct outreach programs by training lay workers from the communities to participate in screenings and health promotion activities, by using local volunteers, and by hiring community residents to staff health clinics. For example, the Centro Médico del Valle, Inc. in Texas is a grass roots community project with a mission to increase bilingual, bicultural access to primary care services on the U.S./Mexico border. Based on community input, the Centro focuses its services on the needs of the local population, employing bilingual and bicultural health care workers sensitive to the traditions and customs of the community. Federally funded community and migrant health centers also incorporate community input into all phases of operations by maintaining advisory boards consisting of at least 51 percent of health center users.

Recommendation: States should identify a process for continuous or frequent input from linguistic minority communities on state health agency policies and programs affecting those communities in order to assure development of culturally and linguistically appropriate programs and policies. Community participation should also be solicited in the needs assessment and evaluation processes.

♦ *Funding* ♦

Almost three-fourths of respondents reported that funding constraints are the greatest impediment to addressing public health needs of linguistic minority populations (Figure 2). Relatively few state agencies were aware of state laws affecting the development of state bilingual programs. In the absence of mandates, many states are unable to commit significant funds to public health needs assessments or ethnic-group specific programs due to severe budget constraints. State health agencies have shown creativity in improvising with low or limited budgets to meet the needs of linguistic minority populations; many rely on volunteer advisory committees, community members and staff to guide agency policy and to provide bilingual, bicultural assistance as necessary. Virginia, for example, encourages limited or non-English speaking clients to bring family members to clinics, as the Department of Health does not have funds for interpreters or translators.[1] Colorado has creatively combined funding from the Maternal and Child Health Block Grant and the federal Office of Refugee Resettlement to support its programs. Having a formal budget, rather than relying on volunteers, makes this program more viable and assures that the Department of Health has control over the quality of linguistic services provided.

State health agencies also maximize the impact of their limited funds by contracting with community organizations and other public health agencies for service delivery and needs assessments. State agencies can assure linguistic access through funding stipulations; 46 percent of respondents require grantees and contractors for health services delivery to have a plan to meet linguistic needs of targeted populations (Figure 1). For example, Massachusetts contracts with community organizations for language and culturally appropriate services. The Department of Public Health funds the Southeast Asian Birthing and Infancy Project, which has a trained community based team of Southeast Asian staff to provide health education, case management and patient advocacy services in an area of the state with particularly low rates of prenatal care among Southeast Asian women.

> **Recommendation: State health agencies should allot resources to assure that linguistic minorities have access to culturally and linguistically appropriate public health services and prevention programs, including high quality translation and interpreter services and culturally competent health care workers.**

♦ *Translations and Interpreting* ♦

Particularly in state health agencies which deliver health services, the lack of multilingual and multicultural staff is viewed as one of the greatest impediments to addressing needs of linguistic minorities. Of the twenty-six states offering health services, 88 percent do have some bilingual staff. The majority of agencies have at least some educational or informational material in languages other than English. Most frequently, non-English health material is translated into Spanish (82 percent of states), Vietnamese (70 percent of states), Cambodian (52 percent of states) and Chinese (21 percent of states). States often contract for translation and interpreting services on an "as needed" basis to work directly with providers and clients, as reported by 57 percent of state agency respondents. Alternatively, states such as Wisconsin and Massachusetts maintain lists of bilingual staff available within the agency or in the community.

Model state programs for translations and interpretations recognize that health education material cannot be translated word for word, and that some terms may require "cultural translation" as well in order to be comprehensible to the target population. Many model programs assess written materials to assure that reading levels are appropriate for the target audience. The Massachusetts Committee for Culturally, Linguistically Relevant Health Education has developed a standardized translation procedure to assure that translations are high quality and culturally appropriate. The process involves translation and back translation of material to assure that the intended meaning has been conveyed. The California

Department of Health pays a differential to bilingual workers who use language skills as part of their job descriptions. Staff must pass written and spoken certification exams in order to qualify for pay differentials.

Community organizations often pay particular attention to the appropriate translation of terms and meaning. The Women and Infants Hospital of Rhode Island, for example, convened a Multilingual Health Care Coalition to develop nine topical public health video tapes. The coalition consisted of health care providers as well as representatives from the Asian and Hispanic communities. Coalition members spent time discussing word choice, translatability of particular terms and concepts, and cultural issues during the video script development process. Another community based program in California, Project Salsa, developed bilingual cookbooks in Spanish and English to incorporate traditional recipes into their nutrition program.

Recommendation: State health agencies should define and enforce quality standards for written translations and interpreting competency.

♦ *Service Delivery* ♦

The majority of state health agencies indicate that language is an important factor in effective service delivery. Eighty percent of state agencies responded that language is average or high priority in the planning and development of service delivery programs. Not all state health agencies deliver services directly; however, among the states which provide direct services, HIV and AIDS programs are the most likely to have some type of bilingual, bicultural services available (92 percent). Ninety-two percent of agencies have bilingual HIV/AIDS information pamphlets or videos available at service delivery sites, 73 percent provide translation or interpretation services, and 81 percent do AIDS- related community outreach. Immunization and TB programs also have some bilingual services available in 81 percent of agencies, and 73 percent of agencies with maternal and child health programs indicated some bilingual services also.

One model state, Wisconsin, has instituted an administrative directive to assure that clients have access to language appropriate public health services. Departmental guidelines require that each division identify staff with language skills, maintain lists of qualified interpreters and translators, advise clients with multilingual signs and brochures about the availability of linguistic services, and develop all program material at the fifth or sixth grade reading level. Another state, Maine, provides technical assistance to independent Native American reservations through public health nurses in the Bureau of Health. The Bureau orients new nurses to cultural and linguistic issues pertinent to reservation populations and provides information to Native Americans on utilizing state resources. Native Americans worked collaboratively with the state to establish and develop Maine's Year 2000 Health Objectives while preserving the sovereignty of their native languages and culture.

Several model community efforts have developed programs to recruit and train bilingual, bicultural health care workers, and also to assist other providers in working with linguistic minorities. The Richmond Area Multi-Services Center in California, for example, has four programs serving predominantly Asian clients. The Center's programs include a mental health outpatient center, the Asian Family Institute, a National Cross-Cultural Training Program for Asian Leaders, and a Korean outreach team to new immigrants. The leadership program selects students from different health related disciplines with an interest in cross-cultural counseling. The program is also developing cultural competence guidelines for health professionals working with Asian clients. Another community program, the Tri-County Health Center in North Carolina, provides primary care to migrant and seasonal farmworkers, 45 percent of whom are Hispanic. Tri-County actively recruits bilingual, bicultural health care workers

and addresses social issues such as living conditions, substance abuse, and domestic violence as well as primary health care.

Recommendation: State health agencies should maintain accurate needs assessments and provide language appropriate services when necessary. Through grant and contract requirements, reporting requirements, and audits, state health agencies should assure that organizations receiving funding from the agency also adequately address linguistic access for targeted populations.

Recommendation: State agencies should work with state and federal policy makers, state and community agencies, communities and other leaders, including the private sector, to replicate effective programs.

Recommendation: Where possible, staff of programs serving cultural and linguistic groups should be representative of the population being served. State health agencies should develop programs and policies which promote recruitment and training of culturally and linguistically competent health care professionals and community health outreach workers from targeted linguistic populations.

♦ *Cultural and Linguistic Competency Training* ♦

Only nine states (35 percent of agencies) have some type of multilingual, multicultural training available through various state health agency programs. For example, the Massachusetts Office of Refugee and Immigrant Health surveyed staff of community based organizations on training needs, and as a result provides periodic cultural competency training sessions for combined staff at both the state and the community level. Trained bilingual, bicultural staff hired within the Massachusetts Department of Public Health act as "cultural bridges" to newcomers. In Utah, the Ethnic Health Project is developing a cross-cultural awareness manual which targets health providers and advises on how to approach health problems in ethnic minority populations with cultural sensitivity and understanding. Topical areas addressed in the manual include reproductive health issues, death, health and wellness, and cultural attitudes.

Two-thirds of state health agencies indicated that a lack of trained multilingual/multicultural health care workers (HCWs) is a major impediment to addressing the needs of LEP communities (Figure 2). Several state and community based health programs have facilitated outreach and communication with limited English speaking communities by training "para-professionals" to work with the targeted populations. The Colorado Refugee Health Care Access Program functions mainly through the use of trained bilingual, bicultural community health workers who inform refugees of available health services and benefits, in addition to interpreting at medical appointments when necessary. One community organization, the International District Community Health Center in Seattle, Washington provides practicum for bilingual, bicultural students from health professional schools in local clinics which serve the mostly Asian clientele. The Cook County Department of Public Health in Illinois, which serves mainly Hispanic clients, organizes Spanish language classes for staff.[2] Initiatives in Florida and Massachusetts are beginning to look into utilizing the skills of foreign trained health professionals to provide services to linguistic minority communities.

Recommendation: State health agencies should define goals and objectives, along with developing and implementing policies, for training agency staff and health providers on multilingual and multicultural aspects of ethnic populations. Training should be aimed at achieving acceptable levels of competence and at a minimum, should address the following issues: cultural values and traditions, family structure, communication styles, attitudes

affecting health behavior, approaches to healing, and traditional folk remedies of the targeted populations. Training should also address mental health issues and stress management.

Recommendations: State health agencies should utilize the skills of non-traditional health care workers where possible. States should consider training members of linguistic minority groups as health outreach workers to facilitate communication with targeted communities. States may also investigate options to utilize the skills of immigrant health professionals who are members of linguistic minority groups, either through licensing procedures or special arrangements with the agency, to provide services to targeted linguistic minorities.

♦ ***Evaluation of Multilingual and Multicultural Program Effectiveness*** ♦

As the Colorado Department of Health put it, it takes "common sense" to know that the most effective way to attend to client needs is to work in the language of the client. The ASTHO needs assessment found little data to directly link bilingual, bicultural health agency programs with outcome or effectiveness data. Many agencies track programs which provide language appropriate services. For example, the Michigan Office of Minority Health tracks which ethnic and linguistic minorities are targeted by each of its programs. The Colorado program sets goals for the number of clients served, tracks the percentage of the target population reached, and reports the data to funding sources. Other bilingual, bicultural programs rely on positive feedback from community organizations and other evidence of community acceptance of programs. The International District Community Health Center in Seattle collects data on the ethnic origin of all clients using clinic services to document increased usage and need for services. Evaluation of linguistic program effectiveness is hindered by lack of race and ethnic specific data as well as the lack of information on the impact of language as a factor in health outcomes and health status. Given the importance of public agencies to justify programs and expenditures to funding sources and legislatures, evaluation is a critical element in the development of language appropriate health access programs.

Recommendation: State health agencies should evaluate public health programs based on established objectives, such as Year 2000 goals, and should emphasize the need for continuous monitoring of both state health program effectiveness and changes in health status indicators in the targeted populations.

Recommendation: State health agencies should systematically survey clients from targeted linguistic groups to assure the effectiveness of state programs and policies designed to promote access to preventive and public health programs. Assessments should address linguistic and cultural relevance of services, use of services, and client satisfaction.

RECOMMENDATIONS FOR COLLABORATING WITH THE FEDERAL GOVERNMENT

The federal government has many policy and program mechanisms in place which target ethnic and racial populations. Several federal offices target specific minority populations nationally. For example, the Office of Refugee Resettlement (ORR) provides health screening for refugees upon entering the United States; the Migrant Health Branch of the Bureau of Health Care Delivery and Assistance (BHCDA) assists migrant and seasonal farmworkers across the country; and the federal Office of Minority Health is responsible for coordinating health initiatives which involve all racial and ethnic groups. Information and referrals pertaining to minority health issues can be obtained from federal centers such as the Office of Minority Health Resource Center, the National AIDS Information Clearinghouse, the Office of Disease Prevention and Health Promotion (ODPHP) National Health

Information Center, and the National Center for Education in Maternal and Child Health. The federal government also has an Office of Minority Health representative in each of the ten Public Health Service Regions responsible for coordinating ethnic and racial minority health initiatives at the regional level. Offices of Minority Health have also been established in the Health Resources and Services Administration (HRSA) and the Centers for Disease Control (CDC) to more effectively assess and address minority health needs.

States report that federal guidelines for grants, contracts, and cooperative agreements often do not contain budget allowances for necessary services, such as developing quality translations and employing certified interpreters. Other federal guidelines fall short of distinguishing necessary services for certain populations. For example, policies and priorities which target Native Americans are inconsistent among competing federal agencies, particularly when states differentiate between the needs of urban and rural Native Americans. Federal and state health agencies have recognized a need to improve and coordinate efforts to better utilize federal mechanisms which assist states in addressing linguistic minority access to the health system. While the recommendations outlined in this report present state health agencies with a "roadmap" for responding to the health needs of linguistic minorities, states acknowledge that the time frame for implementation of recommendations may depend upon federal funding assistance.

Recommendation: The federal government should take a more pro-active role in disseminating information to states on multilingual and multicultural health programs and multimedia materials nationwide, as well as disseminating information on federal grants and policies targeting linguistic minorities, by better utilization of existing clearinghouse mechanisms.

Recommendation: The federal government should insert language in requests for proposals (RFPs) and cooperative agreements to allow states to tailor federally funded projects to specific targeted linguistic minority populations. Funding policies should allow for flexibility in the responses of state health agencies with very small numbers of people in any specific linguistic audience.

Recommendation: Federal policies and programs should take a leadership role in collecting linguistic minority health needs assessment tools and making them available to all state health agencies. Federal financial support should be available to state health agencies for short term multilingual and multicultural programs until needs assessments are conducted and long range planning can be done.

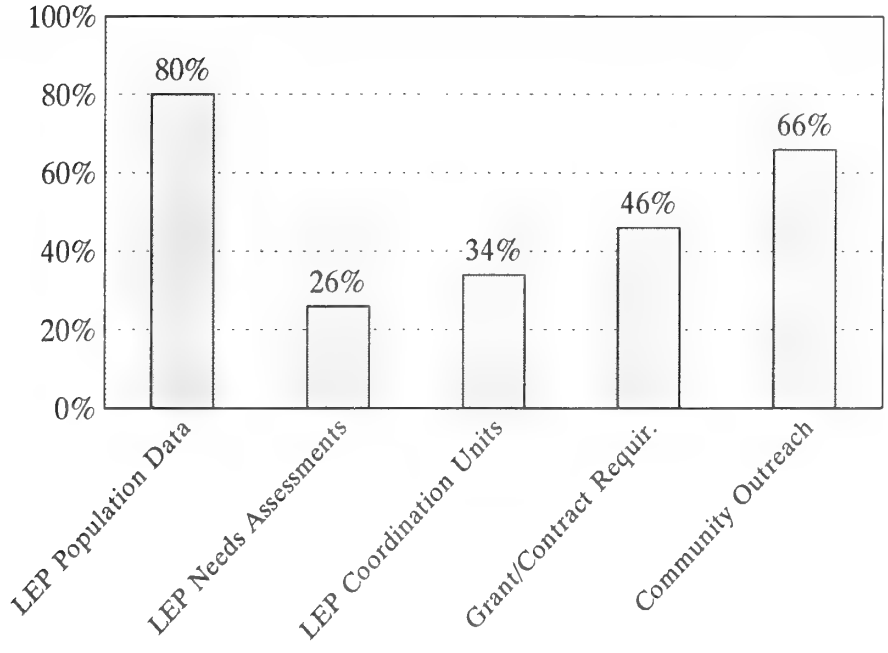
Recommendation: Federal funds should assist states in developing a mechanism for the coordination of ethnic and racial minority health initiatives, such as Offices of Minority Health where desired, and should include staff training.

Notes

1. The use of family members as interpreters can cause a breach of confidence between clients and health providers, and is discouraged by many multicultural advocacy groups, although many organizations use family members to translate as a last resort.
2. Cook County was one of three county health departments to be recognized by the National Association of County Health Officials (NACHO) for their efforts to provide health services to multicultural communities in 1992.

Figure 1

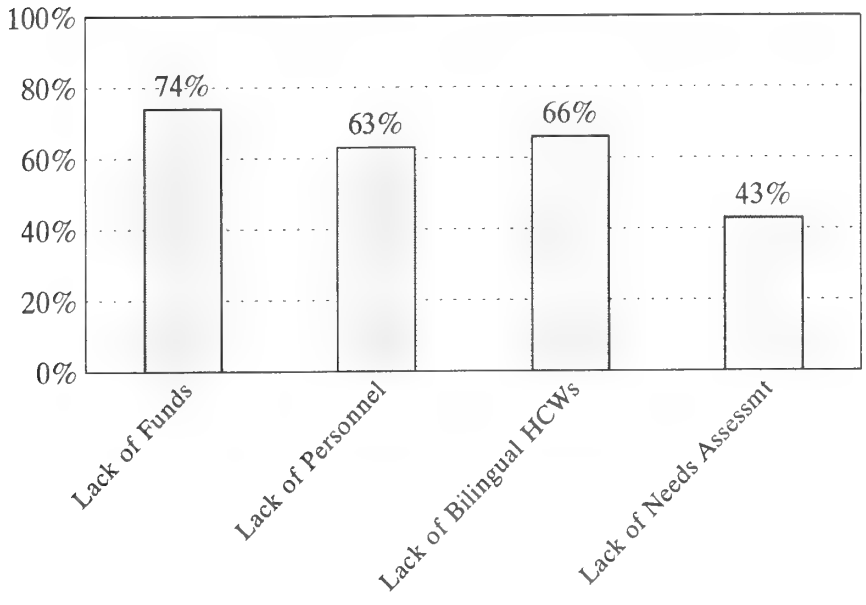
State Health Agency Availability of Linguistically Relevant Policies and Programs



Source: ASTHO Bilingual Health Initiative, 1992.

Figure 2

State Identified Impediments to Addressing Linguistic Needs



Source: ASTHO Bilingual Health Initiative, 1992.

Part III

Case Studies of State Programs Targeting Linguistic Minorities

The five state programs detailed in Part III represent various approaches to responding to the needs of non-English speaking and limited English proficient populations. The Minority Health Advisory Committee selected each health agency because of demographic, geographic, and administrative structures which may be comparable to other states. Each profile describes the state's program in general, definition of the targeted populations, method of public health needs assessment, program development, funding mechanisms, type of community involvement, method of evaluation and follow up of the linguistic appropriateness of the program, state identified needs for programmatic improvements, and the program's transferability to other states. These profiles represent "models" which other state health agencies may be interested in adapting to the specific needs of individual states.

- The **Colorado** profile describes the Refugee Health Care Access Program which combines resources from the state Department of Health and the Department of Social Services to provide the services of bilingual community health workers to refugees.

- The **Massachusetts** profile details initiatives in the Office of Refugee and Immigrant Health to centralize resources and standardize procedures for translations and interpreters, along with assessing needs and evaluating programs for the state's diverse linguistic minority populations.

- The **Michigan** profile highlights activities in the Office of Minority Health which involve coordinating initiatives that target linguistic minorities through a network in the Department of Public Health, in addition to overseeing grants to ethnic and racial community based organizations which deliver health services to targeted populations.

- The **Utah** profile includes projects spearheaded by the Ethnic Health Advisory Committee. The Committee consists of multi-ethnic community representatives who assist the Department of Health in assessing needs and assuring that culturally and linguistically competent programs are developed and that appropriate services are delivered.

- The **Wisconsin** profile describes the administrative directives and affirmative action policies that the Division of Health uses to assure that the state's linguistic minority populations have equitable access to health care. The state assurance mechanisms are public hearings, written requirements for grantees and contractors specifying that services must be linguistically appropriate, and site visits.

For more information on each "model" program, a contact name has been included at the end of each profile.

COLORADO

The Refugee Health Care Access Program, in the Colorado Department of Health (CDH), addresses the health access problems of refugee populations and the communication needs of health care providers through the services of bilingual, bicultural community health workers. The Refugee Health Care Access Program (RHCAP) provides interpreters for refugee clients and conducts presentations on cultural health care habits and beliefs. The Program is co-located with the Colorado Refugee and Immigrant Services Program in the state Department of Social Services.

Targeted Populations

- Through the use of federal refugee funds, the Refugee Health Access Program serves newly arrived refugees who have been in the U.S. for less than 8 months. Funding from the Maternal and Child Health Block Grant targets services to low income refugee women and children in the U.S. less than 3 years.

- Based on state statistics, there are 1,350 individuals in the targeted refugee population. They represent the following ethnic groups: Vietnamese (41%), Cambodian (11%), Hmong (11%), Lao (11%), Soviet (14%), Eastern European (4%), African (4%), Afghan/Iranian (3%). The total refugee population in Colorado includes 6,600 Vietnamese, 2,200 Cambodians, 2,000 Hmong, 2,400 Lao, 2,000 Soviets, 650 Eastern Europeans, 700 Ethiopians and other Africans and 650 from Afghanistan.

- According to the Colorado Refugee and Immigrant Services Program (CRISP), 57% of the adult refugees registering for their employment services in 1991 tested "poor" or "none" for English proficiency. Over 90% of Colorado's refugees are concentrated in the greater Denver area.

Public Health Needs Assessment

Due to the increasing number of Southeast Asian refugees in Colorado in the early 1980's, state health administrators hired an outside health planner to assess the needs of the refugee populations, the availability of health services for these populations, potential funding sources, and federal requirements on refugee funds used for services. The recommendations to the health administrators led to the establishment of the Refugee Health Care Access Program. The argument for recruiting bilingual health workers from the target populations for the Program is based on a "common sense" assumption that the most effective way to attend to client education and information needs is in the language of the client.

The RHCAP aims to improve health indicators of the targeted populations through education and promotion of preventive health practices. A Disease Control Representative with the CDH notifies local health agencies of the new arrivals, so that refugees receive federally funded screening. The Department then tracks the results of the screening and subsequent treatment. In 1991, the Epidemiology Division of the CDH reported a tuberculosis infection rate of 39% among new refugees, a parasitic infection rate of 56%, and a rate of only 61% of new arrivals being up-to-date on immunizations. Health indicators for "new" refugees, such as Russians and Eastern Europeans, are just beginning to be documented.

Program Development

Primarily, the Refugee Health Care Access Program provides an effective communication bridge between refugee families and health care providers. The bilingual staff currently consists of six community health workers who speak English and Vietnamese, Khmer (Cambodian), Laotian, Hmong or Russian, representing the major refugee nationalities in Colorado. Interpretation in other languages is provided through fee-for-service arrangements.

The coordinator of the Refugee Health Care Access Program provides on the job training and direct supervision to the bilingual community health workers. Training includes:

1) education on principles of preventive health care,
2) review of health care delivery systems,
3) standards of routing well-child and maternity care,
4) techniques of contacting, interviewing, and informing refugee families,
5) methodology of assessing the health care needs and making referrals for women and children
6) methods for assessing families' needs for support services and providing case management services,
7) techniques of providing effective interpretation services, and
8) procedures for keeping case records and completing activity reports.

The Program does not pay for the actual health care services. Rather, the bilingual health workers explain the importance and value of preventive health services, assist in making health appointments, arrange transportation, interpret for clients at medical appointments when necessary, and follow up to assure that detected problems are diagnosed and treated and that clients receive periodic well-child care. At a home or office visit, the bilingual health workers identify the refugees' health care needs, complete a health care history on each child, and identify the need for maternity and/or family planning services of the women. The bilingual health workers educate refugees on state and local health programs and benefits such as Medicaid and WIC, as well as make referrals to public health clinics and programs to help clients access the health care system on their own.

The focus of RHCAP continues to be the promotion of preventive health care services for children and reproductive health care for women. These two groups comprise 60% of the refugee population. Objectives based on standards of preventive health care include increasing child immunization levels, early prenatal care, access to reproductive health services, and treatment and prevention of AIDS and hepatitis B. Given the inclination of many refugees to seek care from the American health care system only for curative purposes and not for prevention, the bilingual health workers strive to reach at least 90% of the targeted populations for many preventive objectives and to make significant increases in the number of clients served.

In addition, the Refugee Health Care Access Program gives presentations on the impact of cultural habits and beliefs on refugee health care within the Department of Health, in hospitals, to students in health professions, and to others upon request. Presentations focus mainly on maternal and child health issues. The Program also provides translations of health education materials, especially information on early pre-natal care for women.

Funding

- The Refugee Health Care Access Program receives funding through a cooperative agreement with the Colorado Refugee and Immigrant Services Program (CRISP) which is federally funded by the

Office of Refugee Resettlement (ORR). ORR has proposed to eliminate Refugee Medical Assistance funding, through which RHCAP is funded, in FY 1993.

- One third of RHCAP's funds come from the Department of Health's MCH block grant. The Program continues to look for funds from other appropriate block grants and sources within the Department.

Community Involvement

Recognizing that funding limitations do not allow the program to reach all low-income refugee families who have been in the U.S. less than three years, the community health workers assist the neediest of the targeted populations, such as the more complex cases of children with handicapping conditions and women with high-risk pregnancies. The program has ongoing initiatives to increase the ability of those refugees not eligible for RHCAP services to access health care through the assistance of informed refugee sponsors and community members. The program provides training and technical assistance to Mutual Assistance Associations (community based organizations) regarding health education and health interpreters. RHCAP also provides consultation to private, non-profit refugee resettlement agencies through monthly meetings to educate on the availability and utilization of health care resources.

A Health and Mental Health Advisory group, which consists of agencies serving refugees and public health providers, meets quarterly for information sharing and program planning to assure that community needs are being addressed. The representatives in the Advisory group, ranging from fifteen to twenty-five people, are selected informally by the Refugee Health Care Access Program. This group also serves in an advisory capacity for health and mental health issues to the State Advisory Council on Refugees which meets monthly.

Evaluation and Follow Up

The Colorado Refugee and Immigrant Services Program (CRISP) has begun to collect feedback on programs in a more systematic manner in order to present stronger evidence for government funding requests in a time of shrinking resources. To date, however, the Refugee Health Care Access Program has utilized only informal feedback, which has been very positive, from community health providers, public health agencies, and refugee families themselves on CRISP services and on how the program facilitates bilingual communication for patient access. A recent statewide conference sponsored by CRISP brought together community groups, refugee resettlement agencies and community based organizations, ESOL teachers, and employment counsellors to discuss refugee needs and make a stronger case for the need for increased federal refugee funds.

The RHCAP sets prevention and public health goals and objectives for the program based on standard health recommendations, such as the American Academy of Pediatrics' periodicity goals for immunizations and periodic well-child care. Program goals are similar to the national year 2000 health objectives. The program submits quarterly and semi-annual progress reports on these objectives as part of the funding requirements.

The "para-professional" bilingual health workers are recruited from refugee communities and must pass formal state employment requirements.

State Identified Needs for Program Improvements

- Due to undependable funding, a thorough needs assessment has not been conducted on the refugee population since the original assessment in 1980. The state would like to conduct a needs assessment

of all linguistic minority populations in Colorado, not just refugees. Immigrant populations such as Koreans, have similar needs and could benefit from the bilingual health workers, but do not fall under the definition of the targeted populations earmarked by funding sources.

- The head of the Division of Family and Children Health Services has sanctioned the formation of a cultural competency committee to look at increasing the capacity of programs to serve culturally diverse populations effectively, including linguistic factors. Other Divisions in the Department of Health have not yet initiated formal cultural awareness projects. The RHCAP like to see all programs in the Department of Health examining the needs of linguistic minorities, rather than just one Division.
- The value of bilingual, bicultural staff who are skilled in providing a communication link between limited English speaking clients and health care systems should be recognized as an essential and distinct service need of health care systems which serve substantial numbers of linguistic minorities.
- The Program needs stable funding and more training of bilingual, bicultural "para-professional" health workers.

Transferability to Other State Health Agencies

Other states do similar outreach work on the county level. In states that have a small, concentrated linguistic minority population like Colorado, the state health agency would be able to combine funding sources and effectively run a program like the Refugee Health Care Access Program. The advantage of a state based program is that it crosses county lines and has more flexibility to work with other social service agencies and funding sources.

Contact Person Jan Reimer, Director, Refugee Health Care Access Program (303) 863-8211

MASSACHUSETTS

The Office of Refugee and Immigrant Health (ORIH) in the Massachusetts Department of Public Health (DPH) was established to improve the access and appropriateness of health services and health information for all refugee and immigrant communities throughout the state. The Office promotes culturally and linguistically relevant health care and health education for refugees and immigrants to improve health status and maximize resources. The Office acts as a focal point in the Department to plan programs, train staff, develop policies, monitor legislation, and develop health education strategies on refugee and immigrant health issues.

Targeted Populations

Working with the DPH Refugee Health Program and the Refugee Assistance Program of the Massachusetts Department of Mental Health, the Office conducted extensive needs assessments on the refugee and immigrant populations in the state. According to the definition used by the Department of Public Health, refugees are individuals who are unable to return to their home country for fear of persecution or death due to race, religion, nationality, membership in a particular group, or political opinion. The Office developed extensive fact sheets on each population, including major locations of each linguistic group, demographics, languages spoken, and health and mental health needs of each group. Included in their findings were:

- Approximately one in ten Massachusetts residents is foreign born. One in 45 residents is a refugee.

- The major refugee groups in Massachusetts are: Central Americans (20-30,000 primarily Salvadorans, Guatemalans, and Nicaraguans), Ethiopians (6-7,000), Haitians (60-70,000), Southeast Asians (56,400 primarily Cambodians, Vietnamese, and Laotians), Soviets (16,500), and smaller numbers of Eastern Europeans and Iranians. Major immigrant groups include Chinese (50,000), Portuguese-speakers from Brazil, Portugal and the Azores, and Cape Verde (800,000), and Irish (30,000).

- Health status of these refugee groups is significantly worse than the majority population, as is evidenced by high rates of Tuberculosis, hepatitis B, and stress/trauma related disorders such as depression, anxiety, and high risk for developing substance abuse problems.

- Information from the Massachusetts Department of Education indicates that one out of ten pupils in the state speak a language other than English as their first language, with ninety-five different languages spoken state-wide. Students whose primary language is not English (PLINE) constitute a third or more of all students in seven counties. More than half of all "PLINE" students speak Spanish (55%); one out of ten speak a Southeast Asian language.

Public Health Needs Assessment

Because of linguistic barriers as well as financial concerns and mistrust of organized systems of care, refugee and immigrant populations may not have access to public health programs necessary to health needs. The Department worked with the Refugee Health Advisory Committee and the Latino Health Council, both appointed by the Commissioner of Public Health to identify health needs of refugee and immigrant populations, to assess public health programs targeting specific health problems, and to develop strategies addressing those needs. ORIH also conducted a survey of bilingual, bicultural staff and

supervisors in community based organizations to assess training available and desired improvements at the community level. The Department of Public Health offers courses to address the specific training needs of bilingual, bicultural staff and holds cultural sensitivity training sessions periodically. In general, the Department focuses on developing policies to promote access to health programs for refugees and immigrants by using methods such as 1) developing departmental policies to promote access for refugees and immigrants, 2) providing bilingual, bicultural human services staff that act as cultural bridges to newcomers, and 3) collaboration with federal, state, and local agencies to maximize resources.

Program Development

Many of the programs developed by the Office of Refugee and Immigrant Health were developed in response to identified needs in public health service delivery. Programs developed include:

Perinatal and Pediatric Care. The Southeast Asian Birthing and Infancy Project (SABAI) was implemented through the Refugee Health Program and the Genetics Program in Lowell, Massachusetts, where Southeast Asian women had the lowest rates of adequate prenatal care in the State. The Program now provides health education, case management, patient advocacy, and interpreting services through a community-based team of Southeast Asian staff trained by the Office of Refugee and Immigrant Health, the Refugee Health Program, and the Perinatal Community Initiatives Program.

Substance Abuse. Many refugee populations are at high risk for substance abuse due to stressful living situations, difficulty acculturating, and lack of social support. Substance abuse treatment and information is currently available in English, Spanish and Portuguese, with access to treatment in other languages only available through interpreters. With the Bureau of Substance Abuse Services (BSAS), ORIH now conducts eleven week training courses for bilingual, bicultural human service providers and conducts education and training sessions to familiarize community agency staff with treatment facilities and U.S. treatment methods. The Office makes arrangements for interpreters funded by BSAS and assists in providing interpreter training and some substance abuse educational materials.

AIDS. Many refugees and immigrants know little about HIV, and linguistic barriers impede access to educational and prevention information. The ORIH educates bilingual, bicultural human service providers about AIDS/HIV, develops educational materials in various languages with the AIDS Bureau and the Refugee Health Program, and distributes information to community agencies.

Health Care Services. In order to encourage utilization of health care services and allay mistrust of the governmental system common in refugee and immigrant populations, the Office offered courses on the U.S. health care system for bilingual, bicultural human service providers and collaborated on the "Newcomer's Guide to Health Care in Massachusetts," available in English, Spanish, French, and Haitian Creole. ORIH is also working to increase access to bicultural/bilingual health care providers by facilitating licensing of refugee and immigrant physicians, while also working to improve the availability of interpreter services in hospitals through workshops and the Determination of Need (DON) process. Conditions are attached to the DON approval regarding the provision of interpreter services.

Health Education. ORIH convened a committee of DPH program managers knowledgeable and interested in linguistic minority issues. This Committee for Culturally, Linguistically Relevant Health Education (CCLRHE) assists Department programs in the process for translating, adapting, and developing health education materials for specific linguistic communities. The Committee developed recommendations on improving linguistic access through recruiting, hiring, and supporting bilingual, bicultural personnel at all staffing levels, and through requirements in Departmental grants and contracts. Recommendations of the Committee were endorsed by the Commissioner of Public Health as departmental policy on linguistic access. (See Appendix C for the CCLRHE recommendations.)

Translations and Interpretation. Based on a needs assessment survey of health education materials and translation procedures, the CCLRHE also developed the standard DPH Translation Procedure and a Centralized Interpreter/Translator Pool to assure quality translations and adaptations of health materials for specific communities. The Office maintains a list of qualified translators within the DPH. The translation procedure involves two translators: one translator to do the initial translation and the other to provide a back translation in English, edit, and review the translation for accuracy, tone, and appropriateness. Language-specific Review Committees with members from various ethnic communities are available to review the final translation for reading level and cultural appropriateness of message and graphics.

Funding

- The Office of Refugee and Immigrant Health receives federal funds allotted through the state Office for Refugees and Immigrants, and small grants from private organizations and the state AHEC.
- Individual programs use state and federal funds which are specifically set aside for interpreting and translating services for the Centralized Pool.
- Members of the Culturally, Linguistically Relevant Health Education Committee volunteer their time.

Community Involvement

The Department of Public Health selects members of advisory committees and focus groups from communities. The Refugee Health Advisory Committee, the Latino Health Council, the five Language Review Committees all consist of community representatives. The DPH also involves both state employees and staff of community based organizations (CBOs) in multicultural sensitivity training and educational programs. The DPH does not generally provide direct services; however, competitive grants to CBOs for service delivery must specify how the community organization will target linguistic minority communities. In addition, some of the community needs assessments have been conducted jointly with organizations representing linguistic minority populations. The DPH jointly manages programs such as the Southeast Asian Birthing and Infancy Project, the Amerasian/Vietnamese Health Project, and the Childhood Lead Poisoning Prevention Program with CBOs, and also provides technical assistance.

Evaluation and Follow Up

The Office of Refugee and Immigrant Health evaluates program effectiveness based on yearly objectives of the Office which coincide with the state health goals. One assurance method involves standard quality monitoring of resource people in the Centralized Interpreter/Translator Pool. Community representatives on Language Review Committees check translated materials for appropriate literacy levels and cultural relevance in nine languages. The Office also conducts periodic self-evaluations with input from the advisory committees, which assess what has worked and what has fallen through the cracks throughout the Department. The DPH conducts formal and informal site visits to contracted CBOs to see that they are providing linguistically and culturally appropriate services. Trainings, courses, and programs are evaluated by participants, their supervisors, and instructors.

State Identified Needs for Program Improvements

- The Health Department has indicated needs for more training for bilingual/bicultural staff. Ideal training would be institutionalized, including a comprehensive "degree" program and stipends for presenters.
- More certified medical interpreter and general interpreter trainings are needed.
- More technical assistance to CBOs is needed to develop complete programs appropriate for refugees and immigrants.

- Improvement of hospital interpreter services is needed.

Transferability to Other State Health Agencies

Since cost-containment is a primary concern in state health agencies, Massachusetts believes that Office of Refugee and Immigrant Health has developed a cost-effective program through the use of existing resources and volunteer commitment. A strong network of agencies and individuals with long term commitment to refugees and immigrants makes the programs work. Also, having a central location, like the ORIH, facilitates effective coordination of the Department of Public Health's multi-program approach to improving access to health services for linguistic minorities. The effectiveness of the program in other states, however, may depend on the size of non-English speaking communities and the ability to efficiently incorporate various groups under the umbrella of one program.

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MICHIGAN

The Office of Minority Health (OMH) was established within the Michigan Department of Public Health (MDPH) to give persistent and continuing attention to eliminating the gap in health status between minorities and non-minorities in Michigan. The Office's highest priority is to ensure the development of policies, programs, quality assurance and implementation strategies which are racially/ethnically designed to significantly impact the mortality and morbidity rates within Michigan's minority population. The Office is the vehicle for implementing change by collaborating within the public health system of state and local public health departments and other relevant state and local agencies, including the private sector, to achieve the goal of reducing the racial/ethnic disparity in health status. The Office achieves its goals and objectives through the Minority Health Representatives Network consisting of representatives from each bureau in the agency which have responsibilities in minority health. The OMH operates under the direction of an OMH Advisory Committee which is composed of representatives from the five minority communities recognized by OMH.

Targeted Populations

- The Michigan Office of Minority Health recognizes five minority groups: African American (1,291,706), Hispanic/Latinos (201,596, with Mexican-Americans being the largest subgroup, followed by Puerto Ricans and Central/South Americans), Arab/Chaldean (200,000 Michigan is the only state in the nation that recognizes Arab/Chaldean as a minority group), Asian and Pacific Islanders (104,983, mainly Hmong, Laotian and Vietnamese), and Native Americans (55,638).

Public Health Needs Assessment

In 1986, the Director of MDPH convened a task force composed of health professionals, scientists, and public policy leaders in the state to identify the health needs of Michigan's minority population. One recommendation of the task force, the establishment of the Office of Minority Health, was implemented by Executive Order in 1988.

The Office awards grants to fund projects targeting the five minority communities based on Request for Proposal (RFP) applications. All proposals received are reviewed for the documentation of the health problems and risk factors among the locally targeted minority populations. In addition, the Office has funded two health needs assessments, one statewide in the Native American community and one among the Hmong community in the Southeast part of the state.

Program Development

The OMH currently funds projects statewide in community based organizations (CBOs), local health departments (LHDs), and universities. The Office targets racial/ethnic minorities including linguistic minorities. Funding is provided through intramural and extramural grants. Some of the MDPH programs such as WIC, EPSDT, substance abuse, HIV/AIDS and migrant health services have established initiatives targeted to linguistic minority populations ranging from multilingual brochures to special training for health care providers.

Some examples of Michigan Department of Health initiatives targeting linguistic minorities include:

Community Health Aide Program. The Bureau of Child and Family Services, MDPH administers the Migrant Camp Health Aide (CHA) program. The program was originally developed by the Midwest Migrant Health Information Office in Detroit, Michigan. Bilingual registered nurses train para-professional health advocates from the migrant camps to work with camp residents. The CHAs are effective in working with migrant communities because they speak Spanish, are usually members of the community, and generally originate from the same country of origin as the other residents of the camp. They perform health education activities in the camp and assist residents in recognizing illnesses and risks for illness. CHAs are encouraged to identify health needs in their own agricultural labor camps and to conduct educational programs to address the agricultural labor camp's identified needs.

Bilingual Migrant Resource Directory. Based on recommendations by the intra-departmental Migrant Health Coalition, with representatives from various MDPH Bureaus, the Office of Minority Health developed a Migrant Resource Directory describing the programs and services of the MDPH in English and Spanish. Bilingual health professionals in the Department wrote the Spanish translation. The directory has been distributed statewide to migrant health centers and agencies which provide services to migrants and seasonal farm workers.

Collaborative Projects to Address Minority Health. The OMH staff serve on various statewide health and special group coalitions such as the Diabetes Education, the Minority Health Coalition, and the Hispanic Senior Citizen Coalition. The Office also collaborates with other state departments on initiatives targeting linguistic minorities through the Interagency Minority Health Coalition. The Office has also collaborated with the Vital Statistics Section in defining the racial and ethnic categories and identifying the desegregated data needed to effectively address the needs of each racial/ethnic and linguistic group. Since 1989, the Vital Statistics Section in MDPH has gathered birth and death statistics by racial and ancestry categories. Data on Michigan's Hispanic infant mortality was published for the first time in 1990.

Minority Health Professionals Support. In 1991, the OMH awarded a grant to the University of Michigan School of Public Health for scholarships/stipends for minority students, including bilingual, bicultural students, pursuing careers in public health. The Michigan Association of Local Health Departments was awarded a grant the same year for grants and stipends to minority public health nurses (PHN) and/or PHN's seeking to advance their nursing education.

The Office of Minority Health has also funded several projects targeting linguistic minority populations, including:

Asian and Pacific Islanders. In 1989, the American Citizens for Justice (ACJ) received an OMH grant for $5,000 to convene a task force to begin to identify the health needs among the Hmong community residing mostly in Southeast Michigan. The task force conducted a literature search of needs assessment instruments which had been developed for use among the Asian and Pacific Islander populations across the country. Based on this information and work with staff from the University of Michigan's School of Public Health, the ACJ developed the first draft of the Hmong Health Needs Assessment Tool and compiled a list of health providers and institutions which served the targeted Hmong community. In 1990, the ACJ was awarded another grant for completion of the project. The information obtained from the Hmong Health Needs Assessment is being utilized in the implementation of the Southeast Asian Regional Community Health (SEARCH) project, a project under the auspices of the Ohio Commission on Minority Health. The Detroit City Health Department, Detroit, MI, is one of the three sites for the implementation of the project, with the OMH serving as consultant to the project. The SEARCH project uses members of the Hmong community as outreach workers and advocates in maternal and child health.

Latinos/Hispanics. The Van for Information Screening and Intervention Treatment Project (VISIT) gathers health information and provides screening for diabetes and hypertension in the Hispanic community in Lenawee County, MI. The staff, comprised of a bilingual/bicultural Hispanic outreach worker and a bilingual health educator, visits migrant camps, schools, and churches, using the van as a "mini-mobile clinic". Although OMH funding for the project terminated in 1989, the County Health Department maintains the project on a limited basis.

Arab Americans and Chaldeans. The Arab American and Chaldean Council designs, develops, and disseminates culturally and linguistically appropriate bilingual preventive and health education literature to target populations. The Council conducts outreach activities, such as ten health awareness seminars on cardiovascular disease, hypertension, and life style problems, and attempts to measure the impact of these seminars on the participants' diet and life style. Culturally appropriate projects have also been developed in other community groups to target diabetes awareness.

An OMH funded project with the Arab Community Center for Economic and Social Services (ACCESS) targeted the development of multi-cultural professionals. The project trained twelve medical assistants to disseminate information about health care needs and health care issues of the racial, ethnic, linguistic, and culturally different minorities within the community. The project socializes the trainees to work in health care facilities and programs which serve minority populations and provides summer and permanent job placement assistance to the trainees completing medical assistant's training. Other recruitment and training efforts target Arab Americans/Chaldeans for associate degrees in nursing and administration, with subsequent placement of trainees in health facilities which serve these groups.

Community Involvement

The Office of Minority Health states that it continuously solicits and welcomes feedback from minority communities and incorporates this information in program planning. In 1990, OMH conducted public forums and health seminars throughout the state for the purpose of obtaining information on the health needs of the various minority communities across the state and to identify organizations serving minorities in the area. The OMH also has an extensive statewide Minority Health Network and has held statewide Minority Health Network conferences. From these conferences, public forums and seminars, OMH compiled a mailing list of over 1,800 CBOs, LHDs, clergymen, colleges, and universities. OMH also involves members of the minority community in the reviewing of the proposals submitted to OMH every year.

Funding

The OMH has been funded yearly since 1988 by monies appropriated by the state legislature. A small percentage goes toward OMH administrative purposes, while the majority of the funds are distributed to minority communities through a competitive grant award process. The Office strives to maximize support and resources for the minority communities by promoting collaboration among minority organizations and the existing local public health system.

Evaluation and Follow Up

The OMH requires all projects funded to include a strong evaluation component and to complete the OMH Data Collection Form. The data collection form was developed by OMH to obtain demographic information on the minority groups served, services provided, conditions addressed, and source of funding/source of payment. In addition the projects are required to submit quarterly reports and site visits are made at periodic intervals to monitor the projects.

Some of the programs in MDPH such as the AIDS program conduct literature and media reviews to ensure that the media and literature being used for targeted minority/linguistic groups is appropriate and acceptable to the specific group. The Minority Health Representative in each bureau of the MDPH also assist the OMH in ensuring that the needs of the minority communities are addressed from their respective bureau in MDPH.

State Identified Needs for Program Improvements

- The Office of Minority Health supports a written MDPH policy requiring that all programs originating from and funded by MDPH compile information on the populations served by racial/ethnic categories. When serving populations with linguistic needs, those needs should be documented, appropriate translation of educational materials should be carried out, and interpreters should be made available.

- OMH supports the hiring of more bilingual health professionals.

- The Office also supports training and financial support of bilingual health providers to meet the needs of the linguistic minority populations in Michigan.

Transferability to Other State Health Agencies

The structure of the OMH could be replicated in other states. The Minority Health Representative Network with representatives from each of the different bureaus/offices/centers has proven effective in the MDPH. The data collection form currently used by OMH to obtain information on funded projects is available for use by other states.

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UTAH

The Utah Department of Health has a unique multi-ethnic coalition to provide coordination, direction and oversight of public health programs in Utah. The Ethnic Health Improvement Project is located in the Division of Community Health Services and is charged with eliminating barriers to health care for all ethnic minorities in the state. The Project is guided by a 30 person Ethnic Health Committee, a broad-based formalized coalition of Asian, Black, Hispanic, Native American and Polynesian representatives.

Targeted Populations

- Ethnic minorities in Utah include: 85-100,000 Hispanics, 25-30,000 Native Americans from 5 tribes, 20-25,000 Asians, primarily Vietnamese, Japanese, and Chinese, 18-20,000 Polynesians, primarily Samoan and Tongan, and 12,000 Blacks.
- The Ethnic Health Project works with community based organizations to identify health problems among racial and ethnic subgroups and develop culturally sensitive solutions. Utah also uses U.S. census data cautiously due to sample undercounting of minorities and lack of dis-aggregated data on ethnic subgroups.

Public Health Needs Assessment

- In 1991, Utah held a statewide ethnic minority health conference. At the conference, attendees received materials describing patterns of excess deaths in the minority population and information on health problems. Attendees then participated in working sessions, grouped by ethnic affiliation, to discuss and prioritize health concerns in their own communities.
- The Ethnic Health Project has surveyed specific ethnic communities on physical, psychological, social and attitudinal health. A recent survey on Polynesians was conducted jointly by the Utah State Graduate School of Social Work and the state Office of Asian/Pacific Islander Affairs. The Project, in conjunction with the Office of Indian Affairs and the state Tribal Council, is currently conducting a survey of urban Native Americans. Health department programs, ethnic advocacy organizations, and universities use the needs assessment results to document health needs for grant applications and public education.
- The Project compiles fact sheets on the size and seriousness of disease incidence rates, the effectiveness of intervention, and access issues. Needs assessments conducted by the project also utilize Behavioral Risk Factor Survey data, though information is used infrequently due to sampling limitations which under count ethnic groups.

Program Development

Programs targeting ethnic and racial minorities in Utah are guided by the Ethnic Health Committee. The Committee was established by Departmental statute, and has extensive bylaws describing composition and functions. (See Appendix D for the Ethnic Health Committee bylaws.) The Department of Health requires health assessments of all citizens in the state and stipulates that programs should address the disparity in health status of ethnic populations. The Ethnic Health Committee, which has five subcommittees comprised of three men and three women from each ethnic group, meets monthly to work on objectives determined by the group. Volunteer members are health and non-health related community representatives from all professions and additional resource people. Committee members may be nominated by ethnic community groups and religious organizations which work with the Division of Community Health.

The Ethnic Health Committee has five main goals:

1) work with existing Department of Health programs in order to make the DOH structure more culturally relevant and acceptable.
2) seek funding and resources to address problems identified through needs assessments and community input.
3) develop understanding and awareness of ethnic health needs by means of a newsletter, conferences, public hearings, appropriation hearings, and mass media.
4) plan outreach and training at the state and local level, for both public and private health care providers.
5) make more health related information available in various languages and at the fifth to eighth grade reading level to help people learn healthy lifestyle behaviors and how to utilize existing resources.

Some specific activities and projects of the Committee include:

Cross-Cultural Awareness Manual. The Project is currently developing a Cross-Cultural Awareness Manual which targets health service provider agencies and advises them on how to approach ethnic health problems with cultural sensitivity and understanding. Areas addressed in the Manual include reproductive issues, death, health and wellness, and general cultural attitudes.

Foreign Language Pamphlets. The Ethnic Health Project has received grants to translate health information into an array of foreign languages The programs involved in this initiative are refugee health, immunization, screening clinics, health promotion, chronic disease, communicable disease and emergency first aid. Pamphlets also provide background information on U.S. health procedures to orient newcomers to Utah.

Training Programs. The Committee is developing training programs for para-professionals, especially in the areas of mental health, immunizations, and child emergency medical services. These programs target people from within specific ethnic groups who are part of the culture and language and can be trained to disseminate health information and explain a variety of health procedures.

Community Involvement

The Ethnic Health Committee is the main forum for working with communities, which nominate their own representatives. Department of Health staff work on their understanding of ethnic minority issues and customs by attending religious and cultural events along with members of the Ethnic Health Committee. Events such as Native American pow wows and meetings in Asian congregations provide opportunities for staff to learn about specific ethnic groups, as well as to inform communities of DOH activities. The Department also works with community groups to jointly sponsor health fairs, conferences, task forces, and special committees.

Additional community involvement includes quarterly meetings between the Ethnic Health Committee and the Governor's Minority Health Councils. The four Councils (Black, Asian, Hispanic, and Native American) are comprised of representatives from community based organizations which cover a variety of issues regarding community and economic development. The Committee's participation assures that ethnic health needs are being addressed. Members of the Committee are often asked to sit on policy-making boards in other state departments.

Funding

- The Ethnic Health Project receives general state funds from the Department of Health.
- The Project also receives federal grants from the Office of Minority Health (OMH) and a cooperative agreement from the Bureau of Health Care Delivery and Assistance (BHCDA) which pays for translations and work with state and private agencies.
- Private funding for the Project comes from the American Cancer Society.
- The Ethnic Health Committee members are unpaid volunteers.

Evaluation and Follow Up

The Ethnic Health Project monitors and tracks the incidence and prevalence of disease rates in specific ethnic groups to evaluate changes or improvements. Generally, reliable information is available only on mandatory reportable diseases, although ethnicity based information has been available on nursing homes, hospital discharge data, and home health agencies within the past two years. Other parameters used to evaluate program effectiveness include utilization rates for clinics, immunization rates, and changes in years of potential and working life in linguistic minority populations. The Project also examines other socio/economic indicators such as employment, poverty, insurance rates, and education. Annual division progress reports state accomplishments of the Project based on state health objectives.

State Identified Needs for Program Improvements

- Utah recognizes that lack of staff has prevented the Ethnic Minority Health Committee from accomplishing more. In a number of language-related objectives set out in the Committee work plan, for example, the objectives to assure availability of bilingual and bicultural health translators and outreach workers were not fully achieved. Utah would like to have an Ethnic Health Bureau with 3-4 professionals plus support staff. The current Ethnic Health staff consists of a 30% FTE Director and an additional FTE Program Manager. State funding problems and a hiring freeze have delayed implementation of Committee recommendations.
- The Ethnic Health Committee has identified a need for continued cultural awareness training seminars for all publicly funded programs, not just health-specific programs. Ideally, these seminars should be mandatory for all government employees in order to increase sensitivity and understanding of the effects of cultural differences.
- Utah has determined that the state agency is at a competitive disadvantage compared to other states in terms of salaries. Higher salaries need to be offered to attract more minorities to the state health agency.
- Utah believes that they would be better able to assist ethnic minority groups if federal grants could be restructured to more appropriately address ethnic health needs, particularly with diverse groups such as Native Americans in both urban and rural areas.

Transferability to Other State Health Agencies

The structure of Utah's Ethnic Health Committee could be replicated in other SHAs. The effectiveness of such an advisory committee would depend on the commitment of the volunteer members and the commitment of the health agency to implement recommendations. The Ethnic Health Improvement Project has collected information on minority health issues from other state health agencies and will assist other states in replicating the Utah model by sharing materials they have developed.

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WISCONSIN

The Wisconsin Department of Health and Social Services has developed a strategy to assure access to linguistically appropriate services through enforcement of Title VI of the 1964 Civil Rights Act. The Office of Affirmative Action and Civil Rights, in the Division of Health, is responsible for addressing concerns about limited access and inequitable treatment throughout the Division. Administrative directives and equal opportunity initiatives assure that linguistic minorities have access to health services, participate in the process of identifying health needs, and participate in the development of health programs. The Department requires all providers, contractors and grantees to comply with the standards for "Equal Opportunity in Service Delivery and Employment." These standards require an evaluation of and a commitment to equal service delivery for linguistic minority populations.

Targeted Populations

- Wisconsin has little specific data on adult linguistic minorities. Data sources used to identify potential areas of concern are U.S. Census and refugee health data for Hmong and Indo-Chinese populations. The Wisconsin Department of Public Instruction (DPI) has data on the 70+ languages spoken by students in grades K-12.
- Ethnic/racial initiatives in the State target the following minority population groups: 241,600 Blacks, 96,000 Hispanics, 38,900 American Indians, 31,600 Southeast Asians and 56,900 other minorities.

Public Health Needs Assessment

Assessment by the Division of Health on the needs of linguistic minority communities for language appropriate public health services is both reactive and proactive.

- Reactive -- Administrative Directives and Standards are often initiated in response to individual and group concerns expressed to the Division of Health. Program officials are responsible for responding to concerns of the public in writing, and distributing them for internal review. Program officials then hold public hearings. The Office of Affirmative Action ensures that participation in these public meetings is not limited by linguistic or cultural barriers.

- Proactive -- The Division of Health compiled the need-based report "Healthier People in Wisconsin: A Public Health Agenda for the Year 2000" to determine state public health priorities. Extensive consultation with the state's residents was solicited through public hearings in the five regions of the states. Ethnic and racial minority advocacy and health provider organizations also participated in the process of identifying needs and setting objectives. The Wisconsin Healthy People report does not specifically set objectives for linguistic access; it does, however, set objectives for improving access and health status for ethnic and cultural minorities.

Program Development

The Wisconsin Division of Health operates under an umbrella agency, the Department of Health and Social Services (DHSS). All Division program initiatives are approved by the Secretary of the Department, and funding levels for DHSS programs are approved by the State Legislature. Within the Department, three service programs specifically target linguistic minorities.

Office of Refugee Health. The Office of Refugee Health assures that refugees are brought into the existing health care system. Health-related services for Indo-Chinese residents and visitors range from annual interpreter training sessions for bilingual health aides and general interpreter services to technical assistance for refugee organizations and consultation for health screening and communicable disease control.

Office of Migrant Services. The Office of Migrant Services facilitates program information and assures access to health care services for Hispanics and other migrant and seasonal farmworkers. The Office of Migrant Services makes site visits to community based organizations with migrant health programs to assess policies and procedures of the Division and makes recommendations for solving systematic problems which pose barriers to health care. Migrant Services coordinates programs that cross over the five Divisions in the umbrella agency, the Department of Health and Social Services.

Literacy Assurance. All public documents are checked by the Health Administrator's Public Information Officer to assure that reading levels are appropriate. This includes English documents to be translated into other languages. The Public Information Officer refers Division programs to qualified translators upon request. Some materials, such as a wallet information card on Lyme disease, are developed in direct consultation with migrant groups and pre-tested for appropriate literacy level on the targeted Hispanic population. Directors of both the Office of Migrant Services and the Office of Refugee Health also suggest materials that need to be translated and evaluate the translations for cultural and linguistic appropriateness.

In addition to specific targeted program areas, starting in 1985 the Secretary of the Department spearheaded three initiatives to assure linguistically appropriate health care access for linguistic minorities.

1. Administrative Directive 48 "Procedures for Establishing and Conducting DHSS Public Hearings", obliges the Division of Health to solicit comment from the public on new programs and initiatives and ensure access for everyone, regardless of a person's ethnic or racial heritage. Hearing announcements are published in languages other than English when necessary and interpreters are provided for the hearing impaired and non-English speaking persons upon request.

2. Administrative Directive 52.2 "Interpreters or Translators for Client Services" assures both multilingual verbal and written access to health services. Guidelines enumerated in the Directive include: 1) Division staff will be assessed annually to identify those with foreign or sign language skills who are willing to receive assignments as interpreters or translators; 2) a list of qualified staff, adult volunteers, and outside consultants able to provide interpreter or translator services that meet client needs in each service area will be distributed to all service providers; 3) all clients will be advised in program brochures, flyers, and signs at health sites of the availability of materials in languages other than English, as well as of the availability of translators or interpreters; 4) all program materials will be assessed for reading level, and descriptions at the 5th and 6th grade reading levels will be developed. (see Appendix E for the text of this directive.)

3. The resource manual "Equal Opportunity in Service Delivery and Employment" defines civil rights access to equal employment opportunities and reiterates guarantees of interpreters and translators where necessary to ensure equal access to health services.

Funding

- The Division of Health receives general purpose state funding as well as federal funds from block grants, specifically designated grants, and medical assistance programs. Portions of these funds are designated for programs which are targeted for limited English speaking people.

- Selected health care service providers delivering services under contracts, grants, and agreements with the Division must submit budgets reflecting use of translators and interpreters utilized to provide equal services to linguistic minorities.

- To date, program resources throughout the Division have been distributed according to the availability of funds, specifically towards Native American populations, Southeast Asians, and Hispanics/Migrants.

- The Division is planning to develop a database on LEP adults; at that time the Division will reevaluate expenditures to assure that public health needs of specific linguistic minority groups are addressed equitably.

Community Involvement

- Some offices of the Division, such as the WIC Program, Immunizations,and Environmental Health, contract with community based health organizations to provide service delivery. As noted above, these organizations must demonstrate capacity to deliver language appropriate services.

- Staff of the DHSS conduct regional outreach meetings throughout Wisconsin to hear public feedback on programs.

- Hispanic, Indo-Chinese, and other advocacy groups, as well as concerned individuals bring grievances and suggestions to the Affirmative Action other Division Offices.

Evaluation and Follow Up

The Division requires each health provider that receives $10,000 or more from the Division of Health and has at least 10 employees to develop a plan addressing how services will serve the whole population, including linguistic minorities. The plan must be submitted to the Affirmative Action Office for approval upon request. The Division also conducts on-site monitoring of programs. The Affirmative Action Office investigates complaints to ensure the availability of linguistic access to health services. In addition to regional outreach meetings to obtain input from Wisconsin residents, public hearings are held periodically to follow up on programs and to verify that health services are acceptable to the community.

State Identified Needs for Program Improvements

- The Department has identified a need for more data on the needs of adults in linguistic minority groups. Current data are only available on languages spoken by children in grades K-12. In the next fiscal year, the Administration will be working with the Wisconsin Center for Health Statistics to explore the feasibility of collecting language specific information on adults. U.S. Census data may be cautiously incorporated by the State into planning procedures, after adjusting for undercounting of linguistic minorities due to sampling.

- The Division of Health is working on a minority health initiative to provide a centralized forum for issue resolution. The Division currently does not have a coordinated approach to bilingual and minority health issues. For example, statistics are not centralized and programs are spread out over local, state, and community offices. Budget constraints and staff reductions continue to limit changes that can be implemented in coordinating minority programs.

- The state may identify a need for increased funding once data on adult linguistic minorities is developed. It appears now, for example, that there are less students in higher grades that speak

languages other than English than in lower grades. Taking into consideration the high drop out rate in Wisconsin, the school information may indicate a larger number of drop out among non-English speaking students, who comprise the Division of Health's constituency.

Transferability to Other State Health Agencies

The Administrative Directives and Standards of the Division of Health are need based and could be readily replicated in other states, utilizing the language from Title VI of the federal Civil Rights Act. Also, the affirmative planning approach of public hearings is already in place in most states and can easily be modified to specify that the needs of linguistic minorities must be addressed. Other states could also require grantees and contractors to submit plans for ensuring language appropriate service delivery, which may be problematic in areas such as Medicaid. The success of using administrative policy to enforce linguistic access is greatly affected by the commitment of the state health officer to minority health and linguistic access issues.

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Appendix A

Selected Limited English Proficient (LEP*) Populations in the U.S. by State

State	Total Population	Population Age 5 and over *	Does not speak English "very well" (LEP)	Total LEP Percentage of Population	Spanish Speaking LEP	Spanish Speaking LEP percent of Total LEP	Asian/Pacific Islander Language LEP	A/PI LEP percent Total LEP
Alabama	4,040,587	3,759,802	36,018	1%	14,168	39%	7,920	22%
Alaska	550,043	495,425	22,480	5%	3,234	14%	6,447	29%
Arizona	3,665,228	3,374,806	275,907	8%	187,314	68%	15,472	6%
Arkansas	2,350,725	2,186,665	21,385	1%	10,066	47%	4,310	20%
California	29,760,021	27,383,547	4,422,783	16%	2,960,128	67%	1,061,519	24%
Colorado	3,294,394	3,042,986	109,889	4%	69,100	63%	19,377	18%
Connecticut	3,287,116	3,060,000	184,018	6%	77,972	42%	13,168	7%
Delaware	666,168	617,720	14,569	2%	5,855	40%	2,223	15%
District of Columbia	606,900	570,284	29,128	5%	18,725	64%	3,229	11%
Florida	12,937,926	12,095,284	961,303	8%	729,078	76%	40,465	4%
Georgia	6,478,216	5,984,188	109,050	2%	50,054	46%	28,750	26%
Hawaii	1,108,229	1,026,209	124,418	12%	3,402	3%	117,863	95%
Idaho	1,006,749	926,703	22,296	2%	15,410	69%	2,287	10%
Illinois	11,430,602	10,585,838	657,983	6%	366,999	56%	80,425	12%
Indiana	5,544,159	5,146,160	86,982	2%	31,276	36%	11,017	13%
Iowa	2,776,755	2,583,526	35,407	1%	11,114	31%	8,995	25%
Kansas	2,477,574	2,289,615	48,342	2%	23,574	49%	11,925	25%
Kentucky	3,685,296	3,434,955	29,423	1%	10,890	37%	6,135	21%
Louisiana	4,219,973	3,886,353	128,305	3%	27,942	22%	15,473	12%
Maine	1,227,928	1,142,122	27,759	2%	1,573	6%	2,162	8%
Maryland	4,781,468	4,425,285	148,493	3%	53,198	36%	42,007	28%
Massachusetts	6,016,425	5,605,751	348,786	6%	111,108	32%	56,285	16%
Michigan	9,295,297	8,594,737	188,662	2%	46,144	24%	28,229	15%
Minnesota	4,375,099	4,038,861	79,341	2%	14,200	18%	30,163	38%
Mississippi	2,573,216	2,378,805	24,512	1%	8,890	36%	4,451	18%
Missouri	5,117,073	4,748,704	62,938	1%	20,962	33%	12,852	20%
Montana	799,065	740,218	11,457	2%	2,398	21%	1,054	9%
Nebraska	1,578,385	1,458,904	22,252	2%	8,605	39%	3,673	17%

State	Total Population	Population Age 5 and over *	Does not speak English "very well" (LEP)	Total LEP Percentage of Population	Spanish Speaking LEP	Spanish Speaking LEP percent of Total LEP	Asian/Pacific Islander Language LEP	A/PI LEP percent Total LEP
Nevada	1,201,833	1,110,450	62,168	6%	41,073	66%	12,280	20%
New Hampshire	1,109,252	1,024,621	24,810	2%	3,388	14%	2,573	10%
New Jersey	7,730,188	7,200,696	608,996	8%	311,025	51%	73,390	12%
New Mexico	1,515,069	1,390,048	159,620	11%	119,705	75%	3,753	2%
New York	17,990,455	16,743,048	1,765,526	11%	900,906	51%	278,017	16%
North Carolina	6,628,637	6,172,301	86,814	1%	40,122	46%	16,839	19%
North Dakota	638,800	590,839	11,663	2%	1,052	9%	820	7%
Ohio	10,847,115	10,063,212	189,865	2%	48,080	25%	27,008	14%
Oklahoma	3,145,585	2,921,755	51,885	2%	24,194	47%	11,564	22%
Oregon	2,842,321	2,640,482	78,162	3%	36,181	46%	22,470	29%
Pennsylvania	11,881,643	11,085,170	293,009	3%	88,149	30%	45,009	15%
Rhode Island	1,003,464	936,423	65,927	7%	19,789	30%	7,182	11%
South Carolina	3,486,703	3,231,539	37,757	1%	15,885	42%	6,187	16%
South Dakota	696,004	641,226	12,503	2%	1,363	11%	938	8%
Tennessee	4,877,185	4,544,743	45,524	1%	17,372	38%	10,487	23%
Texas	16,986,510	15,605,822	1,765,723	11%	1,575,652	89%	107,471	6%
Utah	1,722,850	1,553,351	40,825	3%	17,037	42%	10,274	25%
Vermont	562,758	521,521	7,247	1%	757	10%	743	10%
Virginia	6,187,358	5,746,419	161,229	3%	66,625	41%	51,189	32%
Washington	4,866,692	4,501,879	165,207	4%	61,110	37%	71,124	43%
West Virginia	1,793,477	1,686,932	13,594	1%	4,348	32%	1,766	13%
Wisconsin	4,891,769	4,531,134	93,296	2%	28,400	30%	20,812	22%
Wyoming	453,588	418,713	7,266	2%	4,403	61%	583	8%
TOTALS	**248,709,873**	**230,445,782**	**13,982,502**	**6%**	**8,309,995**	**59%**	**2,420,355**	**17%**

Source: 1990 U.S. Census. Note that these data are based on a sample, subject to sampling variability. Numbers reflect self-reported ability to speak English "very well" in the population 5 years old and over.

* All LEP figures are taken from the population five years old and over.

Appendix B

Results of the ASTHO Bilingual Health Initiative Needs Assessment

(Responses from thirty-five states and one territory included)

A. Multilingual Needs Assessment

- 80% of SHA respondents have data or access to data on the number/location of LEP populations.
- 26% have conducted/have access to a needs assessment for linguistic minority populations.
  - 17% have neither data nor assessments on linguistic minority populations.
  - 23% have both data and assessments on these populations.
  - 57% have data on these populations but have not conducted needs assessments.
  - One state (3%) has done an assessment but does not have data.
- 66% obtain input from linguistic minority communities while developing health policy and programs. Methods of community contact include:
  - meetings with community representatives (63%);
  - meetings with local government and public hearings (34%);
  - surveys (20%).

B. Policy Development

- SHAs indicated that written policies on linguistically appropriate health care exist in the following areas:
  - providing educational/informational material in various languages (54%)
  - use of interpreters (46%)
  - cultural sensitivity training for health care workers in SHA (34%)
  - hiring/training bilingual SHA staff (23%)
  - hiring bilingual health care workers in SHA (23%)
- 10 states (29%) commented that although written policies/regulations do not exist, the above areas are addressed in SHAs informally.
- 16 SHAs (46%) indicated that there are written conditions in contracts and grants to local and community health organizations that address appropriate bilingual/bicultural access to health services for LEP populations. The programs with the most written conditions are:
  - HIV/AIDS (69%)
  - refugee health (50%)
  - TB/migrant health (38%).
- 69% indicated that linguistically appropriate training and service delivery are encouraged if specific written policies do not exist.
- 66% do **not** have a central administrative unit for referrals
- 6 SHAs (18%) are aware of state laws that influence the development of state bilingual programs; only 1 SHA (3%) knew of any state laws influencing funding for multilingual state programs.
- 54% indicate that linguistically appropriate service delivery is average priority; 26% high or very high priority, 20% below average or low priority.

- 26 SHAs (74%) responded that funding was the greatest impediment to addressing LEP needs; 66% cited the lack of multilingual/multicultural health care workers; 43% cited lack of a needs assessment; 26% commented that the size of their linguistic minority population was very small.

C. Service Delivery

Twenty-six (74%) of the SHAs surveyed deliver some type of health services. These services tend to be categorically provided in the areas of Maternal and Child Health, Refugee and Migrant Health, Health Education, Chronic Disease, Immunization, STD/HIV/AIDS, TB, Substance Abuse, and Mental, Dental, and Environmental Health. The following percentages correspond only to those 26 SHAs.

- Overall, the number of bilingual services offered across all SHA programs ranges between 3 and 49. Twelve SHAs (46%) offer less than twenty services, and 14 SHAs (54%) offer twenty-one or more.

- Six of the 9 SHAs which have conducted needs assessments deliver health services. Of those 6 SHAs, three deliver more than 20 types of services.

Program Areas

- STD/HIV/AIDS programs in 24 states (92%) have the highest percentage of some type of bilingual/bicultural services available; 16 states have at least 4 services available: 92% have bilingual pamphlets and videos available, 73% have interpreting and translating services, 81% do community outreach.
- Immunization programs and TB programs have the next highest number of states -- 21 (81%) -- with some type of bilingual services, followed by Maternal and Child Health programs, with 19 states (73%).

Multilingual/Multicultural Services

- 9 states (35%) have some type of multilingual/multicultural training available throughout SHA programs; only 3 states (12%) offer training in more than three programs. STD/HIV/AIDS programs (23%) have the most training.
- 24 states (92%) have some bilingual staff in various programs; only 10 states (38%) have bilingual staff in more than four programs.
- Twenty-five states (96%) conduct some type of outreach to linguistic minority communities. 14 states (54%) have outreach in more than four programs.

D. Translations and Interpreting

- 94% distribute educational/informational material in languages other than English. Languages: Spanish (82%); Vietnamese (70%); Cambodian (52%); Chinese (21%)
- 86% provide translation (written) and/or interpretation (oral) for LEP communities. The most utilized methods of delivery include:
  - contracting as needed by individual programs (57%);
  - resource list of available bilingual staff within SHA (30%); and
  - referral list of bilingual contacts outside of SHA (23%).

Appendix C

MASSACHUSETTS DEPARTMENT OF HEALTH
RECOMMENDATIONS ON HEALTH EDUCATION WITH
CULTURAL AND LINGUISTIC MINORITY COMMUNITIES

THE AD HOC WORKING GROUP RECOMMENDS THE FOLLOWING:

RECOMMENDATION ONE

The Commissioner should give high priority to addressing specific areas related to improving access to health services and health information for cultural and linguistic minority communities.

Specifically, DPH programs should:

(1) Define the target populations to be served in terms of cultures and primary languages as well as risk factors.

(2) Develop and implement a plan for hiring bilingual and bicultural staff in both DPH and contracted programs in all capacities for working with the target populations (i. e., program coordinators and directors as well as direct service providers).

(3) Assess the program's need for health education materials, both print and non-print, in languages other than English.

(4) Identify individuals and groups from local cultural and linguistic minority communities who can help plan and implement programs.

(5) Encourage and require through the RFP process that vendors hire cultural and linguistic minorities for all positions as well as appoint members of these groups to agency boards of directors.

(6) Designate funds within their budgets to cover these steps in targeting cultural and linguistic minority communities.

(7) Plan and implement a client data base that would allow for evaluating the use of the services by cultural and linguistic minority clients.

RECOMMENDATION TWO

An office should be created for providing technical assistance on the development of health education materials for cultural and linguistic minority communities as well as the adaptation and translation of English materials. The office should provide assistance to all branches, bureaus, and programs.

An advisory group should also be formed for this office consisting of staff from DPH programs (central and regional offices) as well as external advisors from cultural and linguistic minority groups. This advisory group will: 1) provide input in the planning and development of the materials; 2) assist in identifying and recruiting members of the target community to participate in the development and field testing of these materials; and 3) participate in the design of community dissemination strategies of the materials.

Functions of the proposed office should include:

(1) Assistance in all stages of materials development, including audience identification, message design, media mix, field testing, and production of print and non-print materials.

(2) Identification of written translator services and other materials development resources. The office would facilitate the hiring of bilingual staff to do adaptation and translation by having a master agreement to contract for translators. Individual programs would pay from their budget for any services used and would be responsible for working directly with and supervising the translators. Program staff would work closely with the Office.

(3) Assistance to programs that want to network with print and broadcast media representatives and media production facilities.

(4) Planning and implementation of workshops or in-service training sessions for DPH staff on literacy issues, materials development process, adaptation and translation, alternative health education approaches, etc.

(5) Development of an educational resource clearinghouse that would collect, compile and update the following:

(a) a comprehensive resource list of ethnic media in cities and towns throughout the state, including radio, TV, newspapers, and newsletters;
(b) a catalogue of non-English health education materials at DPH and elsewhere;
(c) community agency needs assessments, socio-demographic and other data on communities throughout Massachusetts;
(d) ethnic-specific data produced by the Division of Health Statistics, the Office of Statistics and Evaluation (BPCAH), etc.; and
(e) a list of minority agencies such as SOMBA or POS that is routinely provided to programs sending out an RFP.

RECOMMENDATION THREE

Culturally and linguistically appropriate health education methods and activities must be developed in conjunction with health education materials. Materials alone are inadequate to get health messages across.

(1) In developing these activities and materials, bilingual and bicultural staff, both within DPH and at contracted programs, should be involved in all phases of program design, development, implementation, and administration.

(2) These staff should receive high quality, appropriate training and support.

RECOMMENDATION FOUR

English materials should be adapted, not merely translated. A procedure for adaptation and translation of health education materials should be developed, circulated, and implemented department-wide.

Such a procedure should include the following:

(1) Print materials for clients and community groups should be simple, clear, and in most cases at a reading level no higher than 4th-6th grade. An assessment of educational attainment and literacy level of the target population should be made prior to developing materials.

(2) Before adapting and translating English materials to another language, the following points should be analyzed:

(a) Goal or purpose of document
(b) Target audience and intended use
(c) Key message(s)
(d) Action expected of audience
(e) Literacy level of audience

(3) The materials should be field tested in the community.

(4) Simple visuals should reflect the target community. Appropriateness of these visuals should be field tested in the community.

(5) All translation should utilize at least two different translators or groups of translators. These translators should use one of the two acceptable translation methods which are:

(a) Back translation in which one translator does the initial translation into the ethnic language and the other translates it back into English; or
(b) Review of the translation in which one translator does the initial translation and the other reviews it.

(6) Translators should meet with the key program person to negotiate differences of opinion regarding the translation. The translated material should be evaluated for terms and dialect differences that may affect understanding in a language group, as well as for effectiveness.

(7) Plans for the distribution and use of the document should be made with advice from members of the target community.

RECOMMENDATION FIVE

A systematic process for materials development should also be developed and implemented department-wide in order to produce effective print and non-print health education materials. The target community should be involved throughout the materials development process in order to develop materials that are appropriate and comprehensible.

The steps in this process should include the following:

(1) Background research and analysis of target audience, including their health beliefs and practices, literacy levels, language, use of media, and materials selection.
(2) Concept development and initial materials design;
(3) Field testing of materials with the target community;
(4) Materials production;
(5) Dissemination of materials; and
(6) Monitoring and evaluation.

RECOMMENDATION SIX

The use of media should be increased to reach and educate cultural and linguistic minorities around a range of public health issues. Radio and television PSAs which include information on DPH programs and community services should be developed and field tested. Media campaigns should specifically target the most at-risk groups. The Department should use Latino, Haitian and other ethnic media, not in isolation, but in conjunction with community outreach and education.

RECOMMENDATION SEVEN

Guidelines for all RFPs and contracts should require the respondent or vendor to demonstrate an ability to develop culturally and linguistically appropriate services that meet the diverse needs of the community. This includes the ability to hire bilingual/bicultural direct service staff; recruit bilingual/bicultural community representatives for the board; provide appropriate and relevant services; provide cultural awareness training to staff and community; and an evaluation process to substantiate these services.

(1) Technical assistance for the development on competitive proposals and services should be made available to community-based ethnic minority agencies. RFP packages should include a list of agencies that provide this type of technical assistance.

(2) Funds must be targeted for developing and purchasing diverse models of services that best meet the cultural and linguistic needs of the community and for training of bilingual and bicultural staff.

RECOMMENDATION EIGHT

Department-wide seminars, in-service trainings, and community-based trainings on health promotion and health education for cultural and linguistic minorities should be held to increase awareness of the special issues and needs of these groups.

RECOMMENDATION NINE

Client-specific data that is collected by DPH and contracted programs should be standardized to include ethnic origin, country of origin, and primary language of clients. Morbidity, mortality, and birth data should also include these variables. Such data is essential in order to plan appropriate services and to evaluate the effectiveness of programs in reaching cultural and linguistic minority communities. These data should also be distributed to community-based organizations.

B Y L A W S

Utah Ethnic Minority Health Committee

Article I: NAME

The name of the organization shall be the Utah Ethnic Minority Health Committee, hereafter referred to as "The Committee."

Article II: PURPOSE

1- The Committee shall promote the physical and mental health of all ethnic minorities in Utah.
2- The Committee shall advise The Utah Department of Health and the Health Advisory Council on all aspects of ethnic minority health and shall recommend policy, programs, approaches and methods for addressing identified concerns.
3- The Committee will stimulate the development of mechanisms for bridging cultural and language barriers.
4- The Committee will be available if asked to educate any legislative committees about the health care needs of Utah's ethnic minority populations, so that decisions are made and resources allocated with an awareness of the needs of these populations.
5- The Committee shall foster cooperation and coordination of public and private agencies and organizations to maximize utilization of resources, in order to improve service delivery and to avoid duplication of services or service gaps.
6- The Committee shall carry on a continuous assessment process to identify problems in services to minorities and to identify the current health status, so as to be able to recommend solutions for improving the operation and efficiency of service delivery programs.

Article III: MEMBERSHIP

1- The Committee shall be composed of at least ten (10), but not more than twenty (20) members. Each member will represent a particular group from Utah's ethnic minorities.
2- Committee members shall be appointed by the Executive Director, Utah Department of Health.
3- Each member is encouraged to have a designated alternate. The names and addresses of the alternate shall be provided by the member to the committee coordinator or secretary, at the first meeting following appointment.
4- New members shall be nominated by any member of the Committee, supported by a simple majority vote of the Committee, then submitted to the Executive Director, Utah Department of Health.

5- Ex officio members will include Staff of the Department of Health, community agencies & local health departments. These members shall provide liaison between their specialized programs, the Committee and its staff.

6- Three consecutive absences from regular meetings, without an alternate member attending in his/her place, without an excused absence, or unless the absence was due to an emergency, may be the basis for removal of a member from the Committee.

7- In order for an appointed member to be removed involuntarily, a recommendation must be made by the committee, resulting from a two thirds vote of the Committee members present, to the Executive Director.

8- A member may resign from the Committee by submitting a written request to the chairperson.

9- Members will be appointed to staggered terms of 3 years. Each person shall be limited to two consecutive terms, after which he/she must wait at least one year before being recommended to be reappointed.

Sub Article: QUORUM

1- A quorum shall consist of a simple majority of appointed members or alternates, as long as there is at least one representative present from four of the five following major ethnic groups: Native Americans, Hispanics, Blacks, Asians, Pacific Islanders.

Sub Article: VOTING

1- Each official member of the Committee shall be entitled to one vote.

2- Alternates may vote when they represent an official member of the committee.

3- Ex officio members, consultants and other observers are not entitled to vote, but may enter into any discussion.

4- Members who are absent and are not represented by their designated alternate lose their chance to vote.

Article IV: OFFICERS

1- The Officers of the Committee shall consist of a chairperson, a vice chairperson, and a third person as a member at large. These three will act as an executive committee. The officers will be chosen by the membership of the Committee for a one year term, and may be reelected for a second year only.

2- A vacancy in any office shall be filled for the unexpired term of that office by a member of the committee elected by a majority of the committee members at the next meeting.

Article V: DUTIES OF OFFICERS

1- The Chairperson shall conduct all meetings of the Committee at which he or she may be present, shall appoint members to sub-committees, and shall coordinate the work of the officers and appointed sub-committees. The Chairperson shall appoint sub-committee chairpersons, with the advice and ratification by a two thirds vote of the Committee.
2- The Vice Chairperson shall act as assistant and shall perform such duties as may be assigned to him or her by the chairperson; shall possess all the powers and perform all duties of the Chairperson in the absence or disability of that officer to act; and shall be next in line to be considered as the chairman of the Committee.
3- The at large member of the executive committee shall assist with subcommittees to see that they understand their assigned tasks and accomplish them in a timely and orderly manner.

Article VI: MEETINGS

1- Utah Ethnic Minority Health Committee meetings shall be held monthly at a regular time and place as determined by the membership.
2- Any time there is insufficient business to meet monthly, the Executive Committee may cancel that month's meeting.
3- Written notice of the time and place of the next meeting of the Committee, together with a copy of the minutes of its prior meeting, shall be mailed to each committee member at least 10 days prior to the next meeting.

Article VII: COMMITTEES

1- The Executive Committee may establish as needed, standing committees and ad hoc committees as needed. All standing committees shall be responsible to the Committee-at-large, which shall act to accept, reject, or to modify the recommendations or actions prior to reporting to the Health Advisory Council.
2- Ad hoc committees will meet to consider a specific concern and be discontinued when the report to the Committee-at-large has been completed.
3- Chairpersons of standing sub-committees shall be selected from the membership of the Committee-at-large. Other members may or may not be members of the Committee-at-large, but are selected for their special expertise.
4- The Committee Chairperson shall designate the membership of all ad hoc committees, including the chairman thereof, with advice and ratification by the Executive Committee.

Article VIII: STANDING COMMITTEES

1- The Executive Committee shall:
   a- Resolve questions involving conflict of opinion among various members.
   b- Recommend Committee action between regular meetings.
   c- Submit reports on its activities to the Committee's regular meetings for ratification or disapproval.
   d- Suggest agenda items of regular committee meetings.
   e- Make task assignments to sub-committees for recommendation to the Committee-at-large.

2- Other permanent sub-committees may be recommended as the objectives and their activities are developed. These sub-committees and their purpose will be added as amendments to these By-Laws.

Article IX: STAFF SUPPORT

Staff support, including program coordination and secretarial services, shall be provided by the Division of Community Health Services.

Article X: AMENDMENTS

The By-Laws may be amended by two thirds vote of the membership of the Committee, with thirty (30) days prior written notice of the proposed changes.

February 5, 1992

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
1 West Wilson Street, Madison, Wisconsin 53702

Tommy G. Thompson
Governor

Patricia A. Goodrich
Secretary

Mailing Address:
Post Office Box 7850
Madison, WI 53707

ADMINISTRATIVE DIRECTIVE

May, 1990 AD-52.2

SUBJECT: Interpreters or Translators for Client Services

1. Background

It is the policy of the Wisconsin Department of Health and Social Services to provide services and information on services to the public in media that will assist individuals in accessing, participating in, and benefitting from Department services.

This policy means that:

a. Information on each program service shall be available in writing, including large print or brailled copies, or on audiotape. Information shall also be available in languages other than English. In service areas with a significant non-English or limited-English speaking population, program information, such as program brochures or flyers, shall be translated into the language of the major language groups. In this case, "major" means that 5 percent or 1,000, whichever is smaller, of the total service area population are non-English or limited-English speaking and that there are 5 percent of the general population or 1,000 people known to speak the same language. (For many programs operated by the Wisconsin Department of Health and Social Services, the service area is the whole state, e.g. Food Stamps, AFDC.)

b. An individual is entitled to the assistance of a qualified interpreter or translator at the time of applying for service, in the receipt of the service, or in the processing of a complaint or appeal.

Interpreters or translators can be qualified staff, qualified adult volunteers, or contracted personnel, who are knowledgeable about ethnic, cultural, and linguistic differences among the different groups affected.

Translators used in the actual provision of services or in client complaint conferences or hearings must be staff,

volunteers or contracted personnel, who are qualified and sensitive to the linguistic and cultural needs of the client; interpreters for the hearing impaired must be Office of the Hearing Impaired or Registered Interpreter for the Deaf certified sign language interpreters.

2. Guidelines

The divisions in the Wisconsin Department of Health and Social Services providing public information or services are required to:

a. Survey employees annually and develop a list of employees with sign language or foreign language skills who are willing to receive periodic assignments as interpreters or translators. The employees who are identified as possessing sign language skills and have yet to undergo an evaluation process are to be referred to the Office for the Hearing Impaired Quality Assurance Assessment Program.

b. Maintain and distribute to division employees who provide services a list of qualified staff, qualified adult volunteers and outside consultants (contracted personnel) who are able to provide interpreter or translator services that meet the client's needs in each service area (e.g., region, district, institution).

c. When program telephone numbers are published, list TDD access numbers to program information. Provide answering machines for TDD numbers which are listed as 24-hour numbers when this is done for voice numbers.

d. Advise people, in program brochures, flyers, and signs at reception area, of the availability of materials in other media or in languages other than English. Advise new program applicants or participants of the availability of translators or interpreters.

e. Check the reading level of all program brochures, flyers, posters, and other materials describing Department/division programs. Whenever possible, develop descriptions using 5th- and 6th-grade reading levels.

Divisions are responsible for paying for qualified interpreters or translators, when qualified staff or qualified volunteers are unavailable.

3. Resources

The Migrant/Hispanic Coordinator and the Resettlement Office in the Division of Economic Support can provide assistance in locating qualified translators. Divisions requiring sign language/oral interpreters should contact the Coordinator of Hearing Impaired Services in the respective DVR field offices

to coordinate interpreter requests. Such requests must be made at least two working days in advance.

4. **Evaluation**

This policy shall be included in the Civil Rights Compliance Plans of each program division required to develop a plan. The implementation of the policy will be discussed at each division's annual meeting on Civil Rights Compliance with the Secretary.

Periodically, the Department AA/CRC Officer will review the implementation of the policy with the other divisions and offices which provide direct services, such as public hearings.

5. **References**

Title VI, Civil Rights Act of 1964
Rehabilitation Act of 1973, Section 504
Chapter 230, Wisconsin State Statutes
Executive Order 28

6. **Originated by:** Office of the Secretary

Patricia A. Goodrich, Secretary

Appendix F

Resources for Linguistically Relevant Health Programs

COMMUNITY BASED PROJECTS TARGETING LINGUISTIC MINORITIES

Multilingual Videotape Project
Women and Infants Hospital of RI
Department of Patient Education
Tel. (401) 274-7410

Multiple Asian Health Services
Richmond Area Multi-Services
Evelyn Lee, Ed.D, Executive Director
Tel. (415) 668-5955

Intl. District Community Health Services
Frank Irigon, Executive Director
Tel. (206) 461-3617

Community Based Nutrition Project
Project Salsa
Nadia Campbell, M.P.H., Principal Investigator
Tel. (619) 594-1976

Border Health Program
Centro Médico del Valle
Petra Reyna, Director
Tel. (915) 859-6403

Migrant Health Center
Michael Baker, Executive Director
Tri-County Community Health Center
Tel. (919) 567-6194

South East Asian Regional Community Health Project (SEARCH)
Elizabeth Chung
Ohio Commission on Minority Health
Tel. (614) 466-4000

Language Survey Report
CA Department of Health Services
Celia Perez-McCauley, Nurse Consultant
Tel. (916) 654-0420

NATIONAL RESOURCES:

Office of Minority Health - Resource Center
P.O. Box 37337
Washington, DC 20013-7337
Tel. 1 (800) 444-MHRC (6472)

National Migrant Resource Center, Inc.
2512 South IH35, Suite 220
Austin, TX 78704
Tel. (512) 447-0770

COSSMHO
(National Coalition of Hispanic Health and Human Services Organizations)
1501 Sixteenth Street, NW
Washington, DC 20036
Tel. (202) 387-5000

National Council of La Raza
810 First Street, NE
Suite 300
Washington, DC 20002
Tel. (202) 289-1380

AAPCHO
(Association of Asian/Pacific Community Health Organizations)
1212 Broadway, Suite 730
Oakland, CA 94612
Tel. (510) 272-9536

Asian American Health Forum
116 New Montgomery St., Suite 730
San Francisco, CA 94105
Tel. (415) 541-0866

American Indian Health Care Association
245 East Sixth Street, Suite 499
St. Paul, MN 55101
Tel. (612) 293-0233
Clearinghouse 1 (800) 473-1926

NOTES:

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